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Crisis Response for Psychosis

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Crisis Response for Psychosis

A qualitative study examining the barriers and facilitators to the provision of crisis care for people with psychosis.

Jonathan Piotrowski

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ABSTRACT

Service users with psychotic illness highlighted dissatisfaction with crisis services. National clinical guidelines recommend the provision of crisis care for those experiencing acute psychosis, however they do not offer clear specifications around the optimal delivery of a Crisis Resolution Team (CRT) intervention for this population.

In response to this need, this study explored the barriers and facilitators to the provision of crisis care for people with psychosis. This topic has not been addressed previously in the literature and the results represent a novel contribution to the evidence base.

Semi-structured in-depth interviews were used in order to examine the views of service users with psychotic illness and CRT staff, to better understand what works well with crisis care and what could be improved. Thematic analysis, utilising a data-driven inductive approach, was used to scrutinise the data in order to identify and analyse patterns and themes.

Four primary themes emerged in the analysis **i). Relationships** – The service user and CRT staff relationship **ii). Communications** – The role of information and knowledge for service users and communication between participant groups. **iii). Features of Psychosis** – The impact of the symptoms of psychosis and risks to selves and others upon delivery of crisis care. **iv). Power and control** - power dynamics in the relationship between the two participant groups and the locus of control for service users in relation to their relationship with CRT staff and at a broader systemic level. The themes were often interrelated, with experiences unique to psychosis meeting with systemic barriers unique to the point of crisis care.

A series of recommendations are made as a result of these findings. These include i). methods to support service users regain control during the acute period ii). The need for a biopsychosocial approach and iii). The need for national guidance around thresholds for treatment of psychosis for CRTS.

DEDICATION & ACKOWLEDGEMENT

This work is dedicated to Laura, Bella and Leo who have supported me endlessly throughout and who have lost me for nearly every weekend over the last year! Thank you.

I would like to acknowledge the guidance and support that I have received from my supervisors; Sarah, Jeremy and Paul. Their advice and feedback pushed me to meet the highest standards.

I would like to thank the Avon and Wiltshire Mental Health Partnership NHS Trust for supporting this study and its commitment to improving mental heath services for those that use them.

Finally, I would like to acknowledge and thank all of those who gave up their time to take part in this study. Despite all of the pressures that the participants faced, they took the time to help improve the experiences of others.

AUTHORS DECLARATION

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED:  DATE: 5 March 2019

CHAPTER ONE - PSYCHOSIS

Definition

The World Health Organisation's (WHO) International Classification of Disease, Tenth Edition (ICD-10) (World Health Organization, 1992) describes 'psychosis' as a 'descriptive term… that does not involve assumptions about psychodynamic mechanisms, but simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour, such as gross excitement and overactivity, marked psychomotor retardation, and catatonic behaviour'.

Psychosis therefore, describes a set of common diagnostic features, relevant to more than one clinical diagnosis.

The National Institute for Clinical Excellence for the treatment and management of psychosis and schizophrenia (National Institute for Health and Care Excellence, 2014) outlines the two broad categories of psychosis:

1. Non-affective psychosis - schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder.
2. Affective psychosis; bipolar disorder or unipolar depression with psychotic features.

Symptoms are commonly characterised by the distortion of reality. Experience of symptoms are unique for the individual. Symptoms are commonly catagorised as 'positive' or 'negative'(National Institute for Health and Care Excellence, 2014).

Positive symptoms are those which are productive – in that they add additional behaviour or perception. These commonly include hallucinations and delusions. Hallucinations refer to when an individual sees, hears, smells, tastes or feels things that do not exist outside their perception. Auditory hallucinations are most common and often manifest in the form hearing voices. Delusions commonly involve the misinterpretation of perceptions or experiences. Delusions are often persecutory – where, for example, an individual believes that people or an organisation intends to cause them harm. Delusional beliefs can also manifest as concerns around one's own health, religion or grandiose beliefs. Other positive symptoms include impact upon language and communication and upon behaviour such as agitation, catatonia or disorganisation (Stahl, 2008).

Negative symptoms are commonly blunted affect, emotional withdrawal, poor rapport, passivity and apathetic social withdrawal, difficulty in abstract thinking, stereotyped thinking and lack of spontaneity (Stahl, 2008). They represent a reduction in normal behaviour or function. Negative symptoms often proceed and follow positive symptoms and the acute phase of psychosis (National Institute for Health and Care Excellence, 2014). While not as dramatic as positive symptoms, which more commonly bring individuals to the attention of health services, negative symptoms often determine whether someone will function well, or have poor outcomes (Stahl, 2008).

Many of these symptoms are not necessarily unique to psychosis. Positive symptoms, such as hallucinations can be experienced by those with cognitive disorders, such as Alzheimer's dementia, or Parkinson's disease. In the case of Charles Bonnet Syndrome, macular degeneration can result in hallucinations. Symptoms commonly associated with psychosis can be experienced by those with Delirium, Lewy Body Dementia, Anton's Syndrome, seizures, sleep disturbance, tumours, or as a result of drug use (Teeple, Caplan, & Stern, 2009). The symptoms of psychosis can be experience by the general population. Increased frequency and impact of of these symptoms, would result in classification of a psychotic disorder.

Incidence & Prevalence

A 2012 meta analysis of 83 studies (Kirkbride et al., 2012), found that the combined incidence rates of all psychotic disorders was 31.7 cases per 100,000 person-years (95%CI: 24.6–40.9). Incidence rates were found to be higher in men than in women before the age of 45, with this disparity particularly pronounced in younger men. This difference in incidence rates between sexes became less above age 45, where rates rise in women around 45-55. The meta analysis found that these reported incidence rates have remained relatively stable, year on year. The rates of affective and non-affective psychosis differ at 12 per 100,000 person-years and 15 per 100,000 person-years respectively (Kirkbride et al., 2012). Additionally, it was found that Incidence rates for black and minority ethnicity (BAME) groups are higher than those for White British ethnicity in the UK, for both men and women. In non-effective psychosis, higher incidence rates were found in more disadvantaged communities, while in affective psychosis there is no evidence of such correlation.

Impact

To experience psychotic symptoms is severely debilitating. In a study that ranked the disabling effects of health conditions in 14 countries, active psychosis was found to be the third most debilitating of diseases – after quadriplegia and dementia (Ustun et al., 1999) .

The impact of psychosis is severe and extends beyond the immediate experience of symptoms. People with schizophrenia die younger than the general population (Walker, McGee, & Druss, 2015), (Brown, Kim, Mitchell, & Inskip, 2010) and It is estimated that in the UK, between only 5-15% of adults with schizophrenia are in employment (National Institute for Health and Care Excellence, 2015). In another study, 25% of people with schizophrenia had severe social disabilities after 15 years, and only 14% had none (Wiersma et al., 2000)

The UK annual economic burden of psychosis has been estimated to be £13.8 billion per annum (£8.8bn non affective & £5.0bn affective), with costs to the UK National Health Service (NHS) making up £7.55bn of this total (Kirkbride et al., 2012). Use of Inpatient services contribute 27% of this total and are the greatest single cost (P. McCrone, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S, 2008). As such, alternative modes of treatment, such as Crisis Resolution Teams can help reduce overall costs and help relieve this impact.

Management of psychosis in the UK

In the UK, oral antipsychotic medication in conjunction with Cognitive Behavioural Therapy (CBT) is recommended for those with psychotic illness (National Institute for Health and Care Excellence, 2014). The British National Formulary (BNF) (Joint Formulary Committee, 2018) suggests use of antipsychotics to relieve acute symptoms and as a prophylactic – with potential for life-long need for antipsychotic medication. However, this assertion is facing scrutiny with the long term efficacy of antipsychotics in question and increasing concern over the effects of antipsychotics upon physical health and brain structure (Murray et al., 2016). Studies are now underway examining benefits and risks of reducing and discontinuing antipsychotic medication compared to maintenance treatment (https://clinicaltrials.gov/ct2/show/NCT03559426).

The National Institute for Clinical Excellence (NICE) Guideline for Psychosis and Schizophrenia in Adults (National Institute for Health and Care Excellence, 2014) makes recommendations around general interventions for this population – Including early intervention services, cognitive behavioural therapy, family therapy, and supported employment. The guideline recommends that early intervention in psychosis services should be offered to everyone with a first episode or presentation of psychosis.

Evidence suggests that the majority of those with a diagnosis of psychosis will be admitted to inpatient hospital services. In a prospective cohort study of 166 people experiencing first episode psychosis (FEP) 80.7% of participants were admitted to psychiatric inpatient care within three years (Mann et al., 2014). A similar prospective cohort study of 104 participants experiencing a FEP, found that 76.9% of participants were admitted to inpatient care within three months (Sipos, Harrison, Gunnell, Amin, & Singh, 2001). Other research found that the likelihood of detention and admission for people with psychosis were increased further for those of Black African ethnicity (Wade, Harrigan, Harris, Edwards, & McGorry, 2006).

Given the likelihood of psychiatric inpatient admission, the acute care pathway is of great importance for those with psychosis. In the UK, psychiatric inpatient admissions are facilitated by Crisis Resolution Teams (CRTs) and as such, CRTs are pivotal in treatment for people with psychosis.

NICE guidelines recommend offering Crisis Resolution Teams (CRTs) as the first line of support to people with psychotic illness, if sufficiently severe (National Institute for Health and Care Excellence, 2015). For people with psychosis using crisis services, NICE guidelines recommend the use of Joint Crisis Plans (JCPs); however, this is at odds with the most definitive evidence (Thornicroft et al., 2013), where a National Institute for Health Research (NIHR) large scale multi-centre randomised controlled trial did not find evidence of effect for JCPs. In this study of 569 participants no significant treatment effect was found for the primary outcome of compulsory hospital admissions (OR 0·90 [95% CI 0·58–1·39, p=0·63]) However, there was some evidence to suggest that JCP were not fully implemented in all study sites.

NICE clinical guidelines do not make recommendations for CRT staff around the principles and general management of a crisis for people with psychotic illness. Whereas, with clinical

guidelines for other diagnoses, such as Borderline Personality Disorder (National Institute for Health and Care Excellence, 2009), such guidance is provided. This represents a substantial gap in NICE guidance, for a population more likely than not, to require CRT support.

CHAPTER TWO – CRISIS CARE

History

The movement to deinstitutionalise mental health treatment was brought to prominence in the 1980's, with inpatient treatment at the time thought to offer little therapeutic effect (Hoult, 1986). The drive to treat in the community, where severity of symptoms or circumstances would otherwise result in an inpatient admission, remains an underpinning principle of UK CRTs.

CRTs were first developed in Australia and the USA in the 1980s (Johnson S, 2008). Despite different health care structures in the US, a movement of deinstitutionalisation occurred around 1950 -1980, similar to that in England (Stein & Test, 1980). Early randomised controlled trials demonstrated positive outcomes of reduced inpatient bed use and patient satisfaction for those using CRTs (Fenton, Tessier, Contandriopoulos, Nguyen, & Struening, 1982), (Fenton et al., 1984) (Hoult & Reynolds, 1984). The early successes of CRTs internationally influenced adoption in England in the 1990s. Where early implementation in a small number of locations, suggested benefits (Glover, Arts, & Babu, 2006).

In 2000, based upon relatively little evidence, the nationwide implementation of CRTs was mandated by UK Department of Health (DoH) The legislation required the provision of CRTs across England, calling for the creation of 335 CRTs to be developed over a period of three years (Department of Health, 2000).

The emphasis for NHS mental health services to ensure that people receive treatment in the least restrictive environment possible, drove the implementation of crisis teams (Department of Health, 2011). As a result, one of the key service recommendations in recent years has been that Crisis Resolution Teams (CRTs) provide acute care whenever possible (P. McCrone, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S, 2008). Acute care refers to an intensive but short term period of health care.

CRT Function

The 2001 DoH Mental Health Policy Implementation guide (Department of Health, 2001) specifications set out the underpinning principle for the delivery of CRTs nationally, many of which were adopted from the Australian model (Hall P, 1991) - namely i). A 24-hour service, 7 days a week ii). CRTs as gatekeepers to inpatient care iii). Treating individuals in the least restrictive manner clinically possible iv). Remain involved with client until the crisis is resolved and service users is linked into ongoing care v). Active involvement in discharge from inpatient services vi) Reduce service users' vulnerability to crisis and maximise resilience.

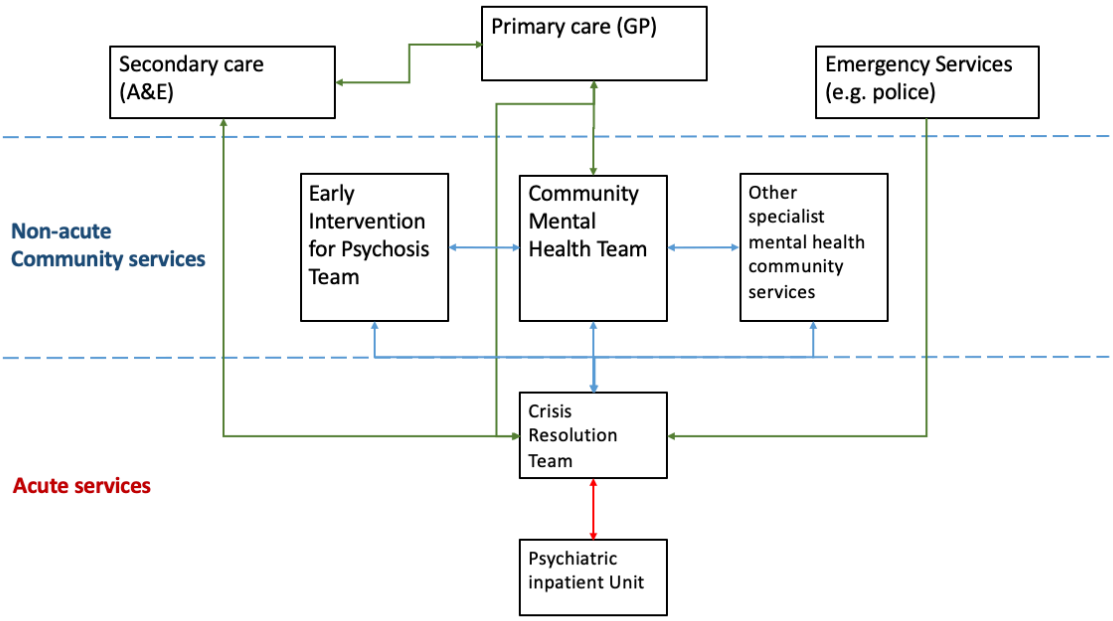
NHS CRTs were developed in order to provide an alternative to inpatient admission, carrying out early assessment of people experiencing mental health crisis and offering intensive periods of home treatment.

CRTs commonly conduct assessments, manage risks and provide treatment to service users in the community. Home visits (or visits at other suitable locations), tend to last for around one hour, although this will vary depending upon need. A CRT may visit a single service user up to 3 times per day in the most extreme cases, where for example the administration of medication requires close attention. Good practice models outline that CRTs should prescribe and deliver medication, offer psychological and social interventions, and address physical health needs through basic monitoring and referral (Lloyd-Evans et al., 2016)

CRTs sit as the last line of community treatment before admission to inpatient care, providing rapid assessment for people presenting with acute mental health problems and referring them on to appropriate services (Department of Health, 2001). CRTs determine whether an inpatient admission is required.

The configuration of secondary care mental health services varies across England, from one Care Commissioning Group to another. Commonly CRTs will receive referrals from primary care (such as General Practitioners), or other points of secondary care (such as accident and emergency), as well as directly from Police Constabularies. CRTS receive referrals from non-acute mental health services (such as Community Mental Health Teams), or specialist community teams (such as Early Intervention for Psychosis Teams). Such referrals are escalations along the acute care pathway, where the severity of illnesses is considered to increase, based upon risks to the individual (this could be in terms of social functioning, distress etc) or others. As gatekeepers for psychiatric inpatient units, CRTs are the only route into and from this form of acute care. Good practice models outline that CRTs should support service users leaving inpatient services and where possible facilitate early discharge. These referral routes are outlined in Figure 1.

Figure 1 – Health service referral routes for people with psychosis



The evidence base for CRTs

There is some evidence to suggest that CRTs are effective in reducing inpatient admissions (S. Johnson, Nolan, Hoult, et al., 2005), (S. Johnson, Nolan, Pilling, et al., 2005), (Patrick Keown, Tacchi, Niemiec, & Hughes, 2018), (Jethwa, Galappathie, & Hewson, 2018), (Glover et al., 2006), increasing service user satisfaction with acute care (S. Johnson, Nolan, Hoult, et al., 2005), (S. Johnson, Nolan, Pilling, et al., 2005), (Patrick Keown et al., 2018), (Jethwa et al., 2018) and reducing health care costs (P. McCrone, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S, 2008) (P. McCrone et al., 2009)

However, in contrast to these positive findings, other studies have found that CRTs have not impacted upon inpatient admission rates (Jacobs & Barrenho, 2011). Other recent evidence has found that rates of compulsory inpatient hospital admissions have, in fact, risen since the implementation of CRTs (P. Keown, Weich, Bhui, & Scott, 2011).

Surveys examining delivery of crisis care have found much variation across England (Onyett et al., 2018) (Lloyd-Evans et al., 2018) and a recent systematic review found little convincing evidence concerning the efficacy of individual components of CRT delivery (Wheeler et al., 2015). Some of the included quantitative studies associated longer opening hours and psychiatrist input, with reducing hospital admission.

In recent years a number of systematic reviews and an NIHR Health Technology Assessment (HTA) have summarised the evidence for CRTs (Wheeler et al., 2015) (Paton et al., 2016) (Murphy, Irving, Adams, & Waqar, 2015). The 2016 HTA in part sought to specifically assess the evidence in relation to the provision of crisis care to people with psychosis, only reiterating the information in NICE Guidelines[2], around the use of crisis plans for this population.

While evidence shows that crisis teams models are preferable to other care models and some research has suggested the routine use of crisis plans, there is no other evidence concerning the best way of working with people with psychosis at the point of crisis care. Again highlighting an important gap in the literature and the need for research.

CHAPTER THREE – STUDY CONTEXT

In the City of Bristol UK, NHS crisis services are provided by the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). Due to the size of the population of the County, crisis services are divided into three hubs; North, Central and South.

In Bristol the need to address the provision of crisis services for people with psychotic illnesses was highlighted in a body of work seeking to engage with the health needs of the population. Bristol Health Partners (BHP) is a collaboration between the city's three NHS Trusts, three Care Commissioning Groups (CCGs), two Universities and Local Authority. The purpose of BHP is to improve the health of those who live in and around Bristol and improve the delivery of health services. The collaboration aims to help change.

In order to achieve these goals, BHP has set up Health Integration Teams (HITs). HITs tackle health priorities by working in new ways. Each HIT focuses upon a specific area of health. Recently the Psychosis HIT (http://www.bristolhealthpartners.org.uk/health-integration-teams/psychosis/) was commissioned to address the health and care needs of this population.

During stakeholder meetings conducted as part of the development of the Bristol Psychosis HIT, AWP service users discussed some of the major issues faced by that population, highlighting their dissatisfaction with the response that they received from local crisis services. Service users described crisis services as 'un-empathetic' and 'inhumane'. The lack of clinical guidance provided by NICE around CRT staff interactions with a psychotic population, may be contributing to these perceptions.

This study represents the first steps in BHP Psychosis HIT's efforts to address these issues. While understanding the pressures staff are under in working within crisis services I aim to develop a series of recommendations around the delivery of crisis care for people with psychosis. To achieve this, I interviewed service users who had used Bristol CRT and staff from those services. I will explore the barriers and facilitators to the provision of crisis care for people with psychosis.

To assess the need for primary research, a literature review was conducted to understand current qualitative research addressing this research question.

CHAPTER FOUR - LITERATURE REVIEW OF QUALITATIVE RESEARCH

Aims

1. To identify qualitative research that specifically examines the barriers and facilitators to the provision of crisis care for people with psychosis
2. If no directly relevant evidence is found, examine whether the search results highlight i). barriers and facilitators to health care generally for a psychotic population, or ii). for service users generally, (with non-specific diagnosis) at the point of crisis care.

Question

What are the barriers and facilitators to the provision of NHS crisis care for adults with psychosis?

Methods

Searches were conducted originally in February 2017 and updated in July 2018. I used a combination of free text and Mesh headings in searches adapted for Medline, EMBASE and PsycINFO. Searches were developed to combine terms describing the topics of psychosis and crisis. Further search terms were used to limit the search results to qualitative studies (full search strategy in ANNEX 1). I devised search strategies and assessed results for relevance to the question. The search strategy aimed to identify studies addressing the research question exactly.

Studies were included if they employed any kind of qualitative research methods. In order to address the research question fully, a study would concern a qualitative account of the accessibility of NHS crisis services for people with psychosis. The literature search was restricted to qualitative methodologies. This approach was adopted as it was considered the most appropriate means by which to demonstrate whether the research question had previously been addressed. As the study aimed to explore the experiences of individuals, qualitative methodologies were accepted as the best possible approach to the research question, as they allow exploration of a topic without assuming prior knowledge and participant led exploration of the research question.

Studies were excluded if they i). did not use a qualitative research methodology, ii). were not published in English language iii). were not published in a peer reviewed journal, and iv). did not address at least part of the research question. Sufficient quality of included studies was inferred by inclusion in a peer review journal. In the initial sift of the search results, studies without an outline of a qualitative research methodology were also judged to be of insufficient quality for inclusion.

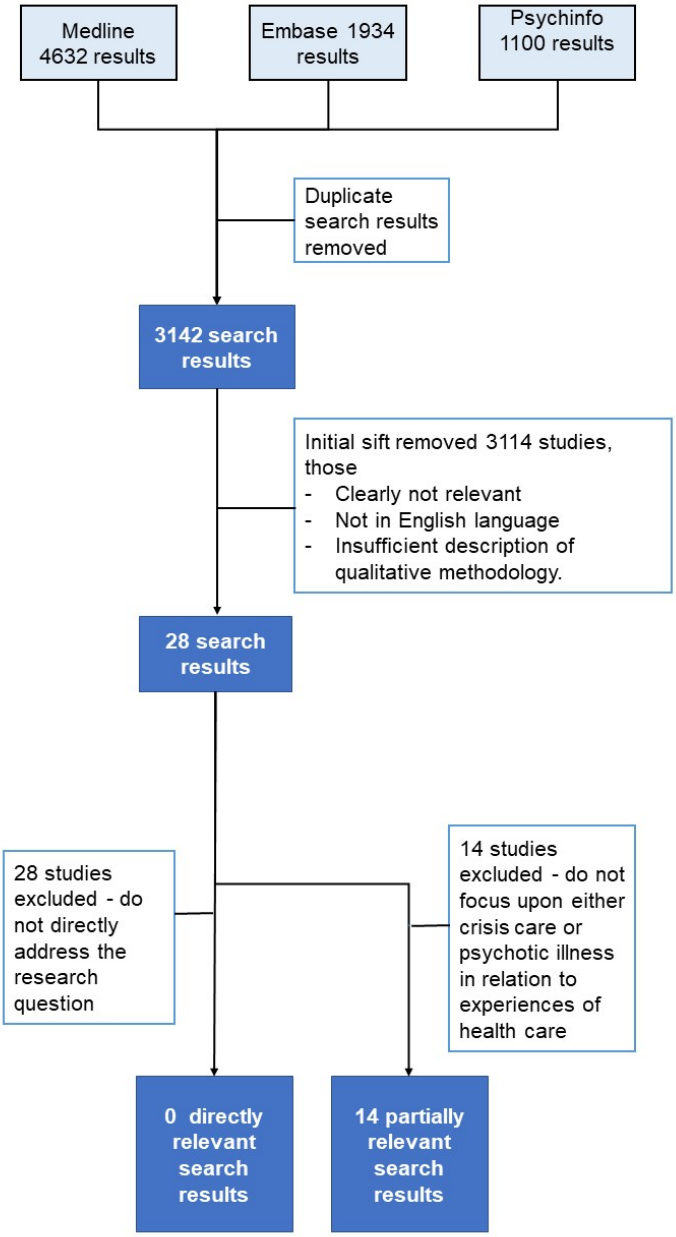
Results

Medline returned 4632 results, EMBASE 1,934 and PsycINFO 1,100, the results from these searches were combined in reference management software. After duplicates were removed I was left with 3142 references. I examined all returned references. From initial screening of the results 3114 were discounted, leaving 28 for further consideration. None of the potential 28 studies directly addressed the research question.

As no evidence was found, I reconsidered the search results, drawing out any qualitative study concerning: i). The views of people with psychosis around the provision of health care, ii). The views of staff around providing health care to people with psychosis and iii). The views of both staff and service users around crisis care.

After a second review of the 28 broadly relevant studies returned in the search I was able to discount 14 references, leaving 14 included in this review. Figure 2 provides a flow diagram describing the literature review assessment of relevance.

Figure 2 – Literature review assessment of relevance flow diagram



Eleven of the included studies originated in the UK, one originated in the US, one Norway and one Australia. *Table 1* provides further classification of the studies.

Table 1

Study focus	
Adults with psychosis	8
Delivery of crisis care	6
Adults with psychosis and crisis care	0
Participant type	
Service users only	7
Mental health professionals only	3
Service users and mental health professionals	4

Table 2 outlines the major findings of the included studies, in terms of barriers and facilitators to the provision of care. A number of barriers and facilitators to the provision of care were highlighted by the included studies.

Levels of resourcing were broadly cited in the relevant literature as influential in the provision of care. For some, resource limitations resulted in pressurised services, preventing continuity of care and the development of therapeutic relationships with service users. Others felt that resource limitations resulted in limited treatment choice for service users, which again acted as a barrier to the provision of care. Meanwhile, where care was viewed as appropriately resourced, through means such as suitable HCP to service user ratio within a service, this was though to act as a facilitator to the provision of care.

Other barriers generally concerned the service user and HCP relationship. Service users highlighted that HCP attitudes can impact the extent that a service user may engage with a service, while HCPs highlighted that a service user's attitudes towards treatment, or illness can impact upon the success of treatment. Meanwhile, where HCPs were viewed to be empathetic, it was thought to improve service users' trust of health services and acted as a facilitator to the provision of care. Features of psychosis were also highlighted as a barrier to the provision of care and preventing engagement with services. Where symptoms of psychosis were viewed to be managed well by HCPs, this was thought to facilitate the provision of care.

Table 2.	**Theme**	**Reference**
Barriers	*Pressured services* - Time pressures and workload barriers were commonly cited by Health Care Professionals (HCPs) as a barrier to the provision of CRT care. These pressures were reported to result in a lack of continuity in visiting staff and appointment times	(Carpenter & Tracy, 2015) (Beecher, 2006) (Prytys, Garety, Jolley, Onwumere, & Craig, 2011)
	Limited treatment/service choice - Both service users and HCPs felt that treatment limitations acted as a barrier to care. Community mental health nurses felt limited to reviews of medication and service users reported a lack of access to the psychiatrist and non-directive counselling. Furthermore, service users found there was poor accessibility to specialist agencies. Service user choices were limited by the ability of services to provide patient preferences. Medication was seen by some as a barrier to coping with voices, with CRTs reliant upon medication as the sole line of treatment	(Beecher, 2006) (M. Coffey, Higgon, & Kinnear, 2004) (Morant et al., 2017) (Tanskanen et al., 2011)
	Population - HCPs reported clinical presentations that can act as a barrier to the provision of care. Symptoms of psychosis were seen to prevent successful crisis care, with symptoms preventing service users from recognising problems as ones caused by psychosis - as such it was often that help would not be sought until crisis point. Concerns regarding the clinical appropriateness of service users' choices were cited as a factor in clinical decision making. Substance use and poor treatment compliance were identified as posing particular difficulties. In working with psychosis some HCPs felt that the need for specialist staff can prevent implementation of NICE Guidelines.	(Beecher, 2006) (Tanskanen et al., 2011)
	HCP Response -Service users stated that HCP responses can result in people feeling misunderstood or ignored, unsafe, vulnerable, anxious, or that they were being judged. In a separate study, unhelpful service responses were outlined as a barrier to care and a service user's prior experiences of crisis care could act as a barrier to engaging with interventions	(Carr et al., 2004; Farrelly et al., 2016)
	Service User Perspectives - Service user perspectives were outlined as a barrier to the provision of care. Some service users held pessimistic views of recovery and treatment compliance were thought of as barriers to successful crisis care. People's worries about the stigma of mental illness and service contact, were also thought to act as a barrier	(Carr et al., 2004; Tanskanen et al., 2011)

Facilitators	*Empathy* - Service users used terms that described an empathetic response from HCPs. Stating that to feel accepted and understood would help with accessibility of services. Similarly, service users suggested that if HCPs adopt a human approach, it would improve their experience. Service users also felt that being enabled to feel safe, accepted, understood and being involved in treatment decisions were important factors of successful crisis care.	(Ferguson, Middleton, Shaw, Collier, & Purser, 2010; O'Toole et al., 2004)
	Managing symptoms Service users discussed the management of symptoms as a facilitator to successful crisis care. This included an overall reduction in symptoms and talking more about the content and meaning of their voices. Staff respondents felt as though the extent that an HCP might engage with psychotic symptoms should be considered, titrated and demonstrating awareness of the personal context of service users.	(M. Coffey & Hewitt, 2008; Shepherd, Murray, & Muijen, 1995)
	Service delivery / resources A Rapid, accessible and crisis-focused approach, flexibility of appointments, greater psycho-and occupational-therapeutic inputs to manage long-term care, practical help (housing, finance, occupation) and increased confidence and independence and the provision of daily structure were all raised as important aspects of service delivery. A high nurse to patient ratio and provision of peer-support with CRTs were thought to be important resources. Earlier input from CRTs was also thought to be an important facilitator for a period of successful crisis care and the role of the CRTs within the care system was viewed as an important part of delivery.	(Carpenter & Tracy, 2015; Klevan, Karlsson, & Ruud, 2017; Lyons, Hopley, Burton, & Horrocks, 2009; Morant et al., 2017; O'Toole et al., 2004; Shepherd et al., 1995)

Conclusion

The need for research in this area is supported by the lack of evidence examining the perspectives of stakeholders on the barriers and facilitators to the provision of crisis care for people with psychosis. The literature search returned 14 studies that were broadly relevant to the research question but did not address it directly. This demonstrates a gap in the evidence base, in relation to the research question. We might assume that the surrounding literature examining i). crisis care for all populations and ii). concerning a psychotic population at different points of care, will, in part, be relevant to this research question. However, it is unclear whether there are specific barriers and facilitators arising for a psychotic population, at the point of crisis care.

The themes arising in the surrounding literature highlight that service provision and available resources, can act as a barriers or facilitators to care. Similarly, the service user and staff relationship was highlighted as influential in the provision of care, with some psychosis specific barriers and facilitators impacting upon clinical relationships. This provides a useful starting point when investigating the barriers and facilitators to the provision of crisis care for people with psychosis and highlights some potential areas of interest to explore with stakeholders.

New research should consider how to bring additionality to the the surrounding literature. Existing research examines the provision of crisis care generally. Rather than repeat the findings of existing research, new research should focus in upon how this differs, or is pronounced for those with psychosis. Similarly, existing research examines barriers and facilitators to care for people with psychosis – new research should concentrate upon crisis care for people with psychosis, focussing in upon the interaction of the unique purposes and specification of crisis care with the experience of psychosis, with aim of developing specific recommendations.

CHAPTER FIVE – METHODS

Aim

The primary aim of this study was to examine the barriers and facilitators to the provision of NHS crisis care for people with psychosis.

Methods

Qualitative methodology was employed in order to gain an in-depth understanding of the barriers and facilitators to the provision of NHS crisis care for people with psychosis, from the view point of both service users and staff. Semi-structured interviews were conducted to examine stakeholders' views around what works well with care and what could be improved.

Interviews were conducted with Bristol CRT staff and service users. CRT staff were asked about the barriers and facilitators to working effectively with people with psychotic illnesses and service users were asked to identify issues with crisis care, as well as aspects of care that they valued. Qualitative methods were chosen as the most appropriate methods to explore medical events as experienced by participants (Malterud, 2001). Semi-structured interviews provided participants with the flexibility to voice their perspective and focus upon the topics they viewed as important (Dicicco-Bloom & Crabtree, 2006). This method of enquiry was selected, as this research questions had not been addressed previously in the literature. As such, I aimed to minimise presumptions around the results of the research and allow as open an exploration of the topic as possible. The methods used were iterative, allowing for understanding of the salient issues to develop throughout the conduct of the research.

Ethical approval

Ethical approval was sought and obtained from the South West – Frenchay Research Ethics Committee. Approval was received on the 9th Dec 2016. The reference for the approval is 16/SW/0276.

Interview participant sampling and recruitment

Purposive sampling was used to include participants so that the maximum variation in views and experiences were captured - reflecting those of a range of staff and service users from the Bristol Crisis Resolution Team.

Bristol CRT clinical staff were purposively sampled in relation to: (i) Site - Bristol Mental Health Crisis services work across three sites in the city (north, south and central areas), (ii) professional role (including managers, mental health nurses, social workers, occupational therapists and unqualified mental health workers) and (iii) socio-demographic variables (age, gender, ethnicity). As an employee of the same NHS Trust as CRT staff and with the necessary authorisation, I directly contacted potential staff participants, via email with an

attached information sheet (ANNEX 2). I also attended CRT staff team meetings and contacted staff by phone. From those that expressed an interest in taking part in the study, a purposive sample was drawn and I arranged an interview at a convenient time and place.

Service user interviews were conducted with people with a diagnosis of a psychotic disorder and that had used the Bristol CRT within the previous three months. Interviews were only conducted with people who had the capacity to provide informed consent and had been discharged from crisis care. Those discharged to primary care were not be eligible to participate, to ensure that if a participant was judged by the researcher to be in need of support, the study researchers could inform the appropriate care team. The sample was selected purposively (Patton, 2015), to recruit a range of socio-demographics and deprivation indices, according to the Index of Multiple Deprivation (IMD2007) score from home postcodes (Noble, 2007).

The study was introduced to service users, face-to-face by a member of CRT staff, who provided a Participant Information Sheet (ANNEX 3). If the service user was interested in taking part in the study, I contacted them by phone and explained the research further and answered any questions. If a service users was still interested in taking part, an interview was arranged. Service users were always initially approached by a clinician that knew them. I only approached service users once they had agreed that this could happen and the facilitating clinician had agreed that it was appropriate for the service user to participate. Issues such as risk and capacity formed part of these considerations.

In order to minimise any distress or perceived pressure to participate, potential participants were recruited to the study once discharged from the Crisis Team.

Sample sizes were determined by data saturation, once new themes had ceased to emerge from the data, this signalled the end of data collection (Sandelowski, 1995). Interviews were analysed in batches, while the interviews continued to take place. This allowed for interaction between interviews and analysis, so as to inform one another (Braun & Clarke, 2006).

Consent

All participants were provided a Participant Information Sheet (ANNEX 2&3). Participants were provided at least 24 hours between receiving the study information sheet and consenting to take part in the study. The information sheet provided them with thorough details of the study including: i). the purpose of the study, ii). what they were asked to do, iii). how their data was analysed and used, iv). the possible risks and benefits to them, v). how the information they provided would be handled and stored and vi). the process by which the study had been reviewed. The information sheet also explained that participants are free to withdraw from the study at any time, without giving a reason for it and with no consequence to their health care. It was also made clear that participants had the opportunity to ask questions prior to providing consent and at any time during and/or after the study. Participants were provided with an email address and telephone number for queries.

Participants were asked to provide their written informed consent to take part, immediately before the interview. The consent form confirmed their understanding of the points outlined on the information sheet and their agreement to take part.

For each participant, their capacity to consent to take part in the study was assessed. In the first instance I considered whether there was an apparent impairment, or disturbance to their mental functioning. If I determined that there was, I made a judgement upon whether the impairment or disturbance inhibited or impacted upon their ability to make a decision about whether they wanted to participate in the study. This judgement was based upon whether the individual was able to understand the information relevant to the study, able to retain that information, use the information and communicate this to me. In one instance, it was determined that a potential participant was not able to retain or use the information and upon this basis, they were not recruited to the study.

Interview Conduct

All interviews were conducted face-to-face; in a location of the participants' choice (e.g. at the participant's home, NHS premises or any other appropriate location). The interviews lasted for approximately one hour. A flexible topic guide was used in order to assist questioning during interviews (ANNEX 4 & 5). The topic guide was developed through consultation with service users with a lived experience of psychosis and the results from the literature review carried out in Chapter Four. The guides were broadly followed with each interview; however, participants were encouraged to discuss the topics they viewed as important, so as to reduce the influence of the researcher upon the topics discussed.

Data Analysis

With informed consent, interviews were audio recorded, fully transcribed, checked for accuracy, anonymised to protect confidentiality and imported into NVivo (Nvivo, 2012) qualitative data analysis software. Analysis began after the first two interviews were conducted, and was ongoing and iterative. Coding of the data was driven by the data itself, without a pre-ordained framework, using an inductive approach (Patton, 2015). As such the codes and themes did not derive from the interview questions, nor the preconceptions of the researcher (Braun & Clarke, 2006). Some topics were added or removed from the interview schedule as the study progressed. This reflected data saturation in relation to specific questions, or the need to explore new topics as they were uncovered in interviews.

Interview transcripts were individually read and re-read to gain familiarity with the data and initial ideas noted. An initial coding framework was developed from this iteration with the first three transcripts. The interview data were analysed line-by-line and coded according to their salience to the research question. The coding framework was developed iteratively, as analysis took place. Emerging codes were developed with reference to existing codes and existing codes reviewed with reference to new codes as they emerged. As codes were developed they were analysed to develop overarching themes. Themes were also developed and modified as emerging codes presented themselves (Braun & Clarke, 2006). Constant comparison (Charmaz, 2006) (G. Glaser & Leonard Strauss, 1967) allowed for the generation of new themes, re-classification of themes and the amalgamation of themes. The coding frame was modified, if needed, as the thematic analysis developed. The data

was scrutinised for differences and similarities within themes across interviewees, seeking disconfirming as well as confirming cases. I led the analysis, and a member of the supervisory team independently coded a subset of three transcripts. Discrepancies were discussed and resolved in order to achieve a coding consensus and to maximise rigour. The entire interdisciplinary research team discussed the preliminary coding framework and themes, to add analytic depth and to ensure that the emerging analysis was trustworthy and credible.

Risks, burdens and benefits

The service user interviews had the potential to be upsetting for participants, as the interviews asked about problems with care and the experience of health care services during a crisis. To account for this risk, the interviewer was trained to be as sensitive as possible. We ensured that the participants were aware of their right to withdraw from the interview and that it was okay to take a break or complete the interview on another occasion, if desired.

To account for risks to a participant's own, or another's' safety, I ensured I knew how to pass on concerns to involved mental health professionals. If I had serious concerns about the participant's or someone else's safety or wellbeing, or the participant had expressed a wish for support following the interview, this process was followed. This was explained to participants in the study information sheet and it was ensured that participants understood instances where confidentiality would be breached.

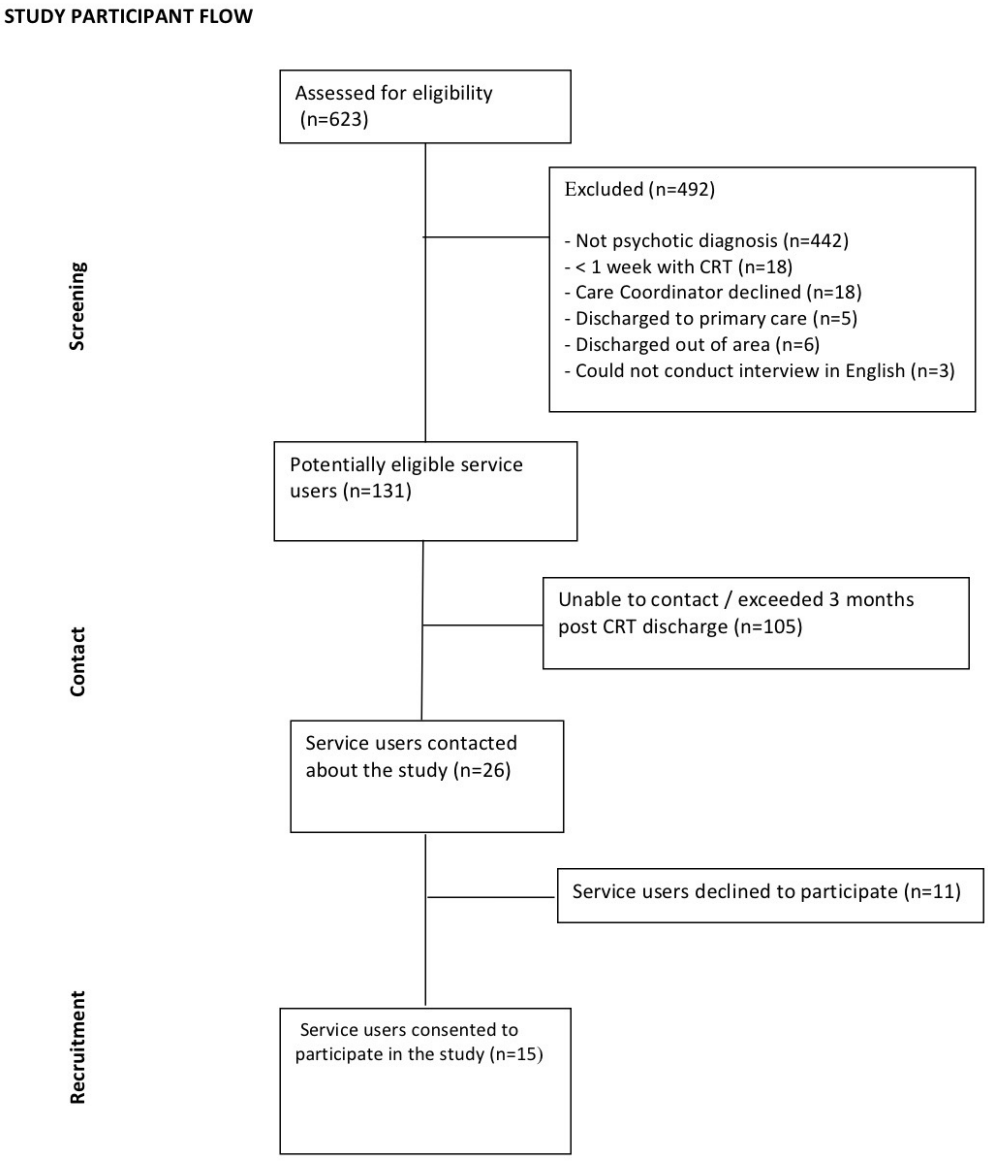
To mitigate risks associated with psychosis, I discussed potential service user participants with a mental health professional involved in their care and sought their views about potential risks and appropriate responses (e.g. only offering to interview someone at the CRT base) for each participant. My training and support emphasised management of risk and the option to terminate interviews if needed. I took appropriate precautions such as carrying a mobile phone and ensuring that someone was aware of the location of an interview, as well checking in after an interview. A protocol was developed for instances where participants may have become distressed (ANNEX 6).

CHAPTER 6 Results – Recruitment

Service User Participants

In total, 623 service users were screened via patient records for the study, 442 of whom did not have a psychotic illness and as such, were not eligible to participate. Details around the flow of participants can be found in Figure 3. Of the total number of service users screened, 2.4% participated in the study. After the application of exclusion criteria, n=131 participants were potentially eligible for the study, 11.5% participated in the study. Of the 26 service users who discussed the study with a researcher, eleven declined to participate, giving a recruitment rate from those approached of 57.7%.

Figure 3 – Study participant flow



15 service users were interviewed between May 2017 and October 2017. Nine service user participants were female and six male. Their age ranged from 24-60 years, with a mean of 39.53 years and a median of 38 years. The ethnicity of service user participants is reported in Table 3

Table 3 Ethnicity of service user participants

Ethnicity	**n**
Chinese	1
Mixed - Asian / white	1
Mixed - Black African / white	1
Other - Arabic	1
White British	11
Total	15

Service user participants were recruited from a variety of locations in the Bristol area. Index of Multiple Deprivation Scores from home post codes were used as a proxy for socio-economic status for participants. Details can be found in Table 4, a deprivation score of 1 represents habitation in the most deprived neighbourhoods in the UK and higher scores represent corresponding deciles.

Table 4 – Multiple Deprivation Scores for service user participants

Index of multiple deprivation score	**n**
1 (10% of most deprived)	4
2	2
3	3
4	3
5	1
6	0
7	1
8	0
9	1
10 (10% of least deprived)	0

CRT Staff Participants

10 CRT staff were recruited to the study between June 2017 – July 2018. The study recruited evenly across the Bristol Crisis services (*Table 5)*

Table 5

CRT Location	**n**
North Bristol	3
South Bristol	3

Central Bristol	3
Across teams role	1

Six staff participants were Female and four male. Their age ranged from 25-50 years, with a mean of 35.9 years and a median of 33.5 years. The ethnicity of service user participants is reported in Table 6

Table 6 Ethnicity of service user participants

Ethnicity	**n**
Mixed - Black Caribbean / White	1
White British	8
White Irish	1
Total	10

Staff participants were drawn from a range of professional backgrounds *Table 7*

Table 7 – staff participants professional background

Profession	**n**
Art Therapist	1
Nurse	1
OT	1
Senior Nurses / team leaders	2
Service Manager	1
Social Workers	2
Unqualified staff	2
Total	10

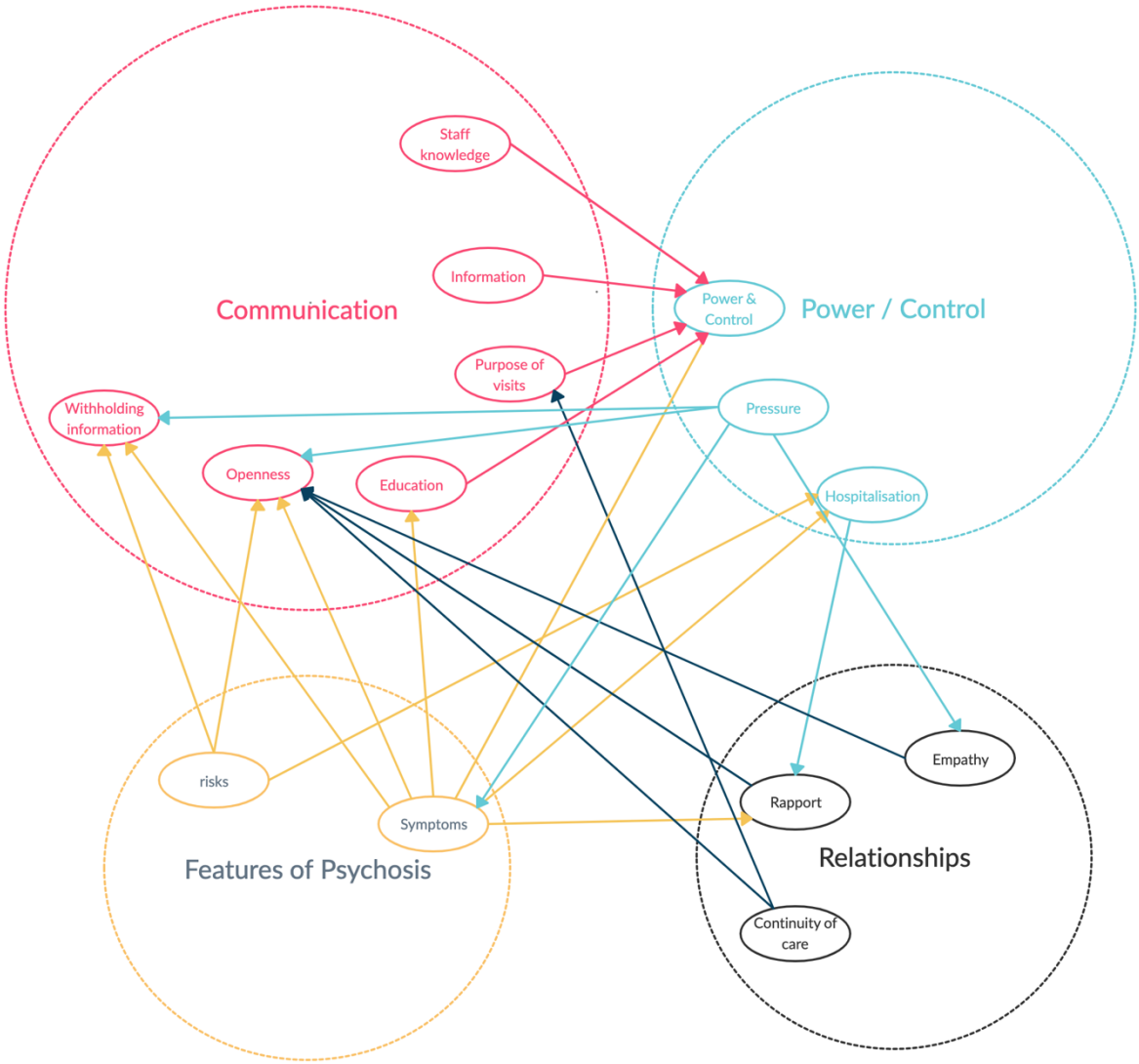
CHAPTER 7: Results

Analysis led to the development of 4 key emergent themes: i). Relationships, ii). Communication, iii). Symptoms of Psychosis and iv). Control / Power. Anonymised quotes are used to demonstrate findings with 'SU' denoting service user and 'ST' denoting staff participants. Staff have been aggregated into a single group to ensure participant anonymity.

The results contain a section devoted to each of the four key themes. Each section provides an overview of the relevant key theme, followed by a more in depth account of the sub-themes that emerged during the analysis of the data.

The four key themes and the related sub-themes were often connected, Figure 4 provides an overview of key themes and the sub-themes and their relation to each other.

Figure 4 – Diagram of key themes and sub-themes and their relation to each other



In four of nine sub-themes discussed by both groups, divergence of views occurred between sub-themes (*Table 8*). Leaving only five out of a possible 14 sub-themes where both service users and staff voiced whole agreement. Demonstrating that differing views exist between groups and highlighting a need for greater shared understanding around the barriers and facilitator to the provision of crisis care for people with psychosis.

Table 8

Theme	*Sub-Themes*	*Concordance between groups?*	*Concordance within service users?*	*Concordance within staff?*
Relationships	Empathy	Y	Y	Y
	Rapport	N	Y	N
	Continuity of care	Y	Y	Y
Communications	Information	n/a	Y	n/a
	Staff knowledge	n/a	Y	n/a
	Education	n/a	n/a	N
	Purpose of visits	Y	Y	Y

	Withholding information	Y	Y	Y
	Openness	n/a	n/a	Y
Features of Psychosis	Symptoms	N	Y	Y
	Risks	n/a	n/a	N
Control / Power	Power and control	N	Y	N
	Pressure	N	Y	N
	Hospitalisation	Y	Y	Y

Of interest, the views of service users did not oppose each other. However, as all barriers and facilitators were not discussed by all service user participants, we cannot presume that they were universally experienced. In contrast, in around half of potential sub-themes, staff expressed a marked, at times contradictory, divergence of views. This points to the need to consider both service users and staff as heterogeneous groups when considering barriers and facilitators to the provision of crisis care for people with psychosis.

The four key themes and subordinate sub-themes are now reported.

Theme 1: Relationships

For both service users and staff, the relationships between the two parties presented important barriers and facilitators to providing crisis care for this population. The analysis revealed the importance of empathy, rapport and continuity of care in developing positive relationships.

Empathy

Around half of staff participants discussed empathy as an important part of providing crisis care and was identified by some as a central tenet to the provision of crisis cares.

> INT: So what do you think makes a good crisis worker?
> ST08: Oh, empathy; empathy, empathy, empathy. We see so many different things and so many different situations, if you go in with preconceived notions of what a person should be doing and what they should look like or any of those things, you're going to fail before you get started, so yeah an open mind, empathy and a good assessor of risk.

Service users valued empathetic staff. Feeling listened to, equated to the sense that staff cared about them.

> INT: …. And what made you feel as though staff were caring with you?
> SU04F: They were just really nice, listened and you know obviously more towards the end when I was a bit more cooperative and stuff like that. They just let me offload.

Other service users also highlighted the importance of feeling as though CRT staff genuinely care about the them, rather than viewing them as a problem to solve. For these service users, this related to a basic human need.

> SU14M: You can tell immediately with a practitioner whether they genuinely care about you as an individual and you can't put that down in words. That's one of those innate things that a human recognises in another human.

> SU03F Yeah, I think part of it is like really caring for the individual rather than seeing you as someone to be dealt with, I hate that language, I don't use it lightly. But like often it's like oh we have to deal with this person or there's a problem to be dealt with. And it's like actually that's not very, doesn't feel very kind, we're all human beings no matter what we're going through.

Other service users described experiences of not feeling as though they were being listened to, or as though they were the focus of sessions. The impact of this was a strong negative perception of CRT staff.

> SU11M: Well I can't say yes, we don't really connect very well to be honest. She'll sit there and she actually had… looking at her bloody phone actually at one point and we were… looked at each other me and [partner's name] and just stood there and sort of went, huh. She just made some comment about multitasking or something or whatever. I thought… you're on the fucking phone, I mean you shouldn't be doing that. It's like me being on the phone. It was incredibly rude.

Just under half of staff highlighted that listening to service users' anxieties and providing a safe space for service users to share their difficult experiences, helps form effective relationships. Failure to do this before seeking solutions, was perceived by staff as damaging to relationships.

> ST02: So I think being able to contain that person's anxiety, showing you can really tolerate hearing the distress and pain and the horrible things people have to live with, if you can really listen to that and empathise, then they'll start to think "This person actually is here and they are starting to understand what I'm saying so maybe I'll take on board what they are saying." I think this is something like on the Crisis line, speaking to people in distress, because you can be very quick to come in with the distractions and coping mechanisms but it just seems insensitive I think to do that too early.

This was discussed further by staff, stating that failure to actively listen and offer an empathetic response, can result in a defensive response from service users. This could lead some service users to feeling belittled and not respected.

> ST02: I think it is about spending the first part really listening. You don't want to jump in too early with your opinion and suggestions and solutions. If they don't feel like you've already listened to them, they don't want to hear what you've got to say.

> They are just going to think, “Who the hell are you coming in and making judgements and telling me what to do?” It’s just patronising

Service users discussed having experienced these two approaches from clinical staff and stated a preference for an approach where they felt as though staff were empathetic and actively listening.

> SU12FA: Just I wondered whether some people were actually listening to me or whether they were writing them down and then passing them off really. I think some people really connected with what I was saying and said, ‘Gosh that sounds difficult,’ or, ‘I really hear you. That must have been…’ that kind of active listening back and others went straight into suggestions and what to do differently. There were two ways of working there and I definitely liked the compassionate one a bit more.

Some service users felt as though CRT staff lacked empathy, finding them desensitised. The impact of this was an impersonal experience of crisis care.

> SU03F: yeah, I don’t know, they’re just a bit impenetrable, that’s the other thing, I don’t know whether they’re just – basically they just haven’t – they’re kind of desensitised to some of the difficulties that people can experience because they’re just like, you know, and they’re going through this like list of things and it’s just, it doesn’t seem very personal sometimes.

Some staff asserted that service users with psychosis are at times, not able communicate their needs and connecting with them on a human level allows for this to be better understood. The staff went on to discuss how pressures upon time can mean that there is insufficient time to discuss contextual life issues.

> ST05FS: It’s like, “I’m so frustrated” and it’s like, “why are you frustrated?” and actually, that person’s not really been taught to communicate their needs or support how to facilitate their needs and I feel like, the people that I work with I speak to people a lot and, actually, when it comes down to it if you can connect with them on a human level ‘do you know what I’m fucking pissed off’, ‘I haven’t got any money’, ‘I’m poor’, ‘I must talk to you’, ‘I don’t give a shit about myself’, ‘yes, I’m hearing voices and yes those are increased, but it’s not medication that’s gonna help me with that it’s all these other things’. We don’t really have time to sit down and talk about depression you know.

Staff also felt that staff fatigue and burnout can result in a lack of an empathetic response, which in turn can result in the needs of service users expressed in unhealthy ways.

> ST05: We deal with lots of high levels of burnout in nursing, well in mental health care and there’s a lot of issues about staff retention… if someone’s stretched it might be they’re not picking up on and they’re not listening and again, it’s going back to communication and having empathy fatigue and perhaps you’re not switched on, or not really listening and tapping into what those needs are and then they come out in the wrong way.

Rapport

Both service users and staff described rapport as an important facilitator to effective crisis care for people with psychosis. For some staff rapport is described by as a central tenet to providing crisis care. Good rapport between CRT staff and service user was described as basis of a trusting therapeutic relationship.

> ST01F Yeah, absolutely, it's huge [rapport], I mean, it's – the trusting relationship is the basis of all the work we do, it's the basis of most therapies, is having a trusting relationship with the therapist, as it were.

This was matched by the experience of service users who valued relationships with CRT where they had a good rapport – feeling supported and treated with respect.

> SU14: Yeah, the best practitioners that I've met are the ones that at the end of it they feel like friends and the way that they've treated you, they've treated you with the utmost respect. I have had those other practitioners that are much more perfunctory, much more blinkered and slightly narrow minded and they just want to go through the process with you. They don't allow conversations to go off point and I think that's not always conducive to good treatment sometimes. Yeah, you treat them as a person and allow fluid conversation to help an individual.

This contrasted with the views of some staff who felt as though the need to maintain a professional role, can be in conflict with a service user's need for a friend-like relationship.

> ST05: Sometimes they just need a friend, and actually we're not, we're professionals

One member of staff discussed a conflict in purpose between providing crisis care as a short term intervention and offering therapeutic intervention. Leading to a barrier to effective rapport.

> ST02: I don't know, this is where I have a bit of conflict between my crisis role and my therapist role because as a therapist I'd be able to see that person week after week and work things through and I would be able to play and explore and wonder and then know that I could go back to those issues again with that person the following week, whereas when someone's in crisis and they're seeing a crisis situation, it feels irresponsible to do that, don't know if this is the time or the place.
> INT: Irresponsible?
> ST02: Yeah, if you're always afraid of, you know, of validating your worst fears and making things worse for them and you don't want to escalate a situation. You don't want to send somebody over the edge. I don't know, it puts you in a difficult position, I think.
> INT: Could anything be done differently to help with that as a team?
> ST02: I don't know.
> INT: No?
> ST02: No.

INT: It's a tricky one.
ST02: Yeah.
INT: It being short term means that it can lead to open a can of worms.
ST02: Yeah.
INT: You're not able to help that person through it in a short space of time.
ST02: Yeah, I had a client one time that used the expression, she felt she was a fizzy bottle that had been shaken up and she just needed to let the lid off slowly and that stuck with me. It feels like that's what you need to help people to do. If you take the lid off quickly it will just explode all over you.

A number of service users suggested that when CRT staff match their own characteristics, such as gender, age, race and sexuality, it can improve rapport. Where characteristics were matched, it resulted in service users describing staff as better relating to their issues. Service users also indicated that rapport can stem from shared understanding and similar personalities.

SU05F: they were all good! But there was two girls of a similar age and we just got talking more and I think that she was called [NHS staff name]. I think she came I few times that I remember.
INT: OK, you felt that there was some consistency there?
SU05F: not so much consistency, but their character as people, they were just like, they just talked to me more, they were like more in tune to what I was talking about.

Another service user reiterated the benefits of matching the characteristics of staff with service users, along with the benefits around a sense of a connection between the parties. They also outlined that a lack of rapport, that can be developed through this method, can result in a feeling of alienation.

SU08: Yeah but I think the biggest thing and probably lots of the time I do say this is that you don't know who you're going to get and I don't think everyone's the same and I just think there are certain people who would come round who I would maybe trust. Maybe probably more women but not necessarily all women and I know there's some men I would trust and I think being mixed race as well, being bisexual as well, there are other kind of things that maybe should be taken into account cause the kind of closer, I don't know, it's not, you know the closer that person is to kind of your demographics, the more likely you are to kind of have some sort of bond or have some…
INT: Shared experience.
SU08: … something, yeah. And if, kind of, there's none of that there then it's like an opposite kind of person who has no reflection can be a bit alienating.

Continuity of Care

Staff spoke of difficulties in developing rapport due to limitations that can arise from the format of CRT delivery and time limited home visits. Further to this, a lack of continuity in the staff that visit service users can act as a barrier to good rapport.

> ST05FS: it's about having a therapeutic relationship with someone and knowing them and if someone's got years and years and years of having psychotic episodes, then it is very specific for them. I don't necessarily know that you'd have in that front-line assessment when you meet them, 45 minutes to an hour to go through all of that and it depends, they might be really disturbed and distressed then it depends on their input and recovery because a lot changes and sometimes if they haven't had the same worker consistently it's really about having a care coordinator on board and you don't always have that because of the changes, staff retention.

Other staff reiterated that a lack of continuity of care can result in service users visited by numerous staff. In the context of psychosis, symptoms of paranoia and distrust can amplify negative impact upon developing good rapport and a therapeutic relationship.

> ST02: The fact that it is different people all the time can make it difficult because if someone is quite paranoid and mistrustful, they might have got along with one member of the team and might agree to working with that person but then, because of the way shifts work out, that person might not be on again for another two or three days, so yeah, that can make it a bit difficult.

For service users, a lack of continuity of care can result in a depersonalised experience of care. Failure to consider service user preferences and historic information about a service user can lead to barriers to good engagement and relationship with care.

> SU08: it felt like two people have turned up to see someone who is in a crisis, that's what it felt like. Rather than two people who have turned up to see me in a crisis when there have been a couple of other admissions so you would have thought they'd be some information and they would think well okay let's close the door, let's keep this private, you know, and maybe I just speak to one person on their own, I would prefer that and I would feel more comfortable and maybe just…

Several service users felt as though their experience would be improved if they were able to select the CRT staff that they see.

> SU12FA: Every single one of them did it differently which I don't know I feel like it would be helpful because everybody is going through it differently so some of the people that I spoke to that helped me might not help someone else but I know a few times when I rang I hung up because I knew that I'd spoken to that person before and although they were lovely, they all spoke to me with respect, they all had different ways of working and I remember calling and asking for a certain person because that person just clicked with how to support me really.
> INT: What do you think they could do to try and improve that for people?
> SU12FA: It's tricky. I always wish that the people that I clicked with were there and always accessible which obviously isn't possible because someone can't work 24 hours a day but I feel like the option to choose who you need, having that kind of option… because they never offered that to me, they never said, 'Well, these four people are in today. Is there anybody in particular that you would like to see?' I feel

like that would be quite hard for me to do because I wouldn't wanna offend anybody but at the same time when you're in that crisis you just know what would be helpful and what wouldn't be sometimes, and if you know that you've just got to believe in picking the right thing.

Six service users discussed the number of different CRT staff that visited during a period of care. Five of those six felt as though changing staff, impacted in different ways. Commonly service users highlighted that being seen by a high number of staff acted as a barrier to developing rapport.

> SU11M: … Seeing six… all different people coming round didn't really sort of get off the ground. I just sort of felt well overwhelming, you know… it's better to see one person if you get on. You should have the option I suppose to sort of decide. You know, if there's a load of people who come round, to sort of say okay, I'd like to see such and such, you know. I know that might be difficult but ultimately you want to get on don't you.
> INT: Yeah, so you said that loads of different people came round and you don't get much grounding, is that what -
> SU11M: Because different people going away sort of with a different report essentially, that you're not going to see them again, so you know, what they do… sort of chatting to someone else and passing it on. It's like no, it just seems a bit pointless really. I don't know what that achieves, loads of different people coming round, because they're not… they might achieve it if I suppose they were helping me but when someone's just coming round and they're saying, well how are you, what have you been up to, well I could just turn round and say that to you and you'll be like, well I don't want to tell you about my boring day or what I've done. Would you really want to hear about everything I've done today?

Service users described being required to repeat themselves due to the number of staff they were required to see.

> SU10A: At the start it was… I thought I would have preferred like the same person to come round because I find sometimes it was like you were telling the people the same story over and over again.

In another case a lack of continuity of care resulted in a perceived lack of empathy from CRT staff, ultimately resulting in the service user pulling away from the CRT

> SU08: That was one of the tough points. I had gone to this group thing [activity] class and I walked out because I was uncomfortable and I felt – I didn't know whether I regretted it, I just kind of felt bad about it and yeah so I called them and they were just like, they wouldn't even answer, it was just like 'Why did you walk out?' and I just felt it was really kind of, there was no empathy, there was no, you know, I wasn't passed to any of the woman I had met or even the care co-ordinator, you know, nobody kind of I knew…. it was like, not at all warm and it was almost an accusing kind of voice so I just put the phone down because I thought 'Well, you know it's not really why' yeah a call for someone to say 'Well why did you walk out

> the [activity] class?' you know, I don't know I just came out of hospital like a week ago, I've been trying to do lots of things to improve things and get through this without having to go back.

Theme 2: Communication

Many of the issues discussed by both service users and staff concerned communication. This theme emerged as an important factor in the provision of crisis care for people with psychosis. Communication was described as both a facilitator and barrier to the provision of care by service users and staff and encapsulated 6 sub-themes: information, staff knowledge, education, purpose of CRT visit, withholding information and openness.

Information

The availability of information was highlighted as important for service users and was viewed as a tool by which they were able to regain some control over their experience. Service users discussed information around psychosis, their experience and seeking support.

When describing the experience of psychosis, service users described extreme confusion and difficulty retaining information at the time of crisis.

> SU01: I have literally at the time when I had my episode, I needed, it was like I was a five year old that needed somebody to look after me, I resorted back to a five year old, I couldn't even take my own pills, I couldn't even understand what was going on, I couldn't understand the conversations that was going between me and the other people and I didn't even and when it came to collecting my prescription and didn't even, when it came to collecting my prescription and my medication at the doctors, I couldn't remember if I had already picked it up, I got lost several times in [place name] and I live in [place name].

Despite the difficulty in understanding and retaining information, service users valued the information they were provided around symptoms of psychosis, as they were able to refer to it once symptoms had subsided.

> SU12FA: Yes. I did receive some information at the beginning about hearing voices which was helpful information and actually I still have it so that I can refer back to it because I don't think I read it immediately when they gave it to me. I only think I read it a bit later on when I felt a bit better. That was helpful and probably will continue to be helpful because I can go back to it.

As well as information about psychosis, service users expressed a desire for information about their experience to better understand it.

> SU07M: I think timelines are quite useful things, for that period. I found myself wanting to do that and I've done it informally. It's just this was what was going on then, this is what was happening then.

INT: That's useful from NHS Services as well, you think?
SU07M: Maybe their impression or perspective of what— because they come quite regularly like you say and just what's going on for you when they came each time, that would be interesting to see where it went and what needs intervention almost.

Overall service users felt as though a directory of information, informing how to access support for common problems for people with mental health conditions, would be beneficial and empower them to be able to find the information that they need.

SU01 … so there is not a lot of stuff available for people that suffer from mental health. There is a lot more now, but there isn't enough. I feel like there needs to be a book with all these numbers, all these pages.
INT: A directory.
SU01 A directory yeah, to say everything that's in there to help people that suffer with mental health and why isn't there?
INT: Like employment advice, financial advice, health …
SU01 Yeah because obviously you do for employment don't you and you get your advice there, but there needs to be some kind of book that says okay so if you have like a local directory or something, advice on who you can have, when you return to work, advice on should you disclose information to your work, just things like that.

Staff knowledge

Staff were seen by service users as an important source of education. Service users particularly valued and felt assured by staff who they understood to be knowledgeable.

SU13FA: They [CRT staff] were always so professional, always so caring, even Dr [name] a psychiatrist with over 30 years' experience, actually coming out to see me and trying to find out what … I can't speak highly of Dr [name] enough, an absolutely lovely man.
INT: You said they felt caring, what kind of made you feel like that do you think?
SU13FA: In the way that I could ask him questions about what's causing this, is it a chemical imbalance, yes and somebody with 30 years knowledge, somebody who has dedicated their life to psychiatry.

Service users perceived CRT staff with knowledge around psychotic experiences, as assured and stated a desire for input of this sort.

SU07M: Yeah, I think they came across— they were just nice people, quite calm and listened and things like that. I've met some staff who maybe carried less authority than others, some staff seemed to really know a lot and be quite assured in that and others were a bit more maybe personable. I don't know, yeah, that's interesting.
INT: Did you prefer one style or another?
SU07M: I think I liked particularly my interaction with the planned consultant or whatever… yeah, the people who seemed to have knowledge around what I was experiencing

The ability of CRT staff to share knowledge around psychosis had a positive impact for service users. It had the impact of normalising their experience and as a result, relieved the isolation described by service users.

> SU07M: I think there's something about the episode or experiences I had which were so vivid and intense and were important to me in that sense because I saw that they were not related to reality. They'd had a much more effect on me and so I was looking for some clarity. I guess that's what I liked about it, is they were able to say that's quite usual or describe back to me in their language, describe back to me things I might be experiencing and that kind of normalises it.
> INT: I can understand what you're saying there and why you think it's important?
> SU07M: It was important because otherwise it would have been easy to feel—experiencing something and because the experience was quite lonely anyway, it felt quite lonely, and that's because it was internal. So much of it was happening inside my thought life that anything that broke through that and pointed out that this was an experience that other people have as well was useful.

Education

Five staff members discussed the role of education, in providing care for people experiencing psychosis. Some staff felt as though education was important for this population, as generally they are not provided with information as routinely as service users with different diagnoses.

> ST10: I think there are resources available and I think we do know the importance of educating people about psychosis, and families as well.

> ST08: Certainly one thing that I've noticed in mental health in general is that I don't think people with the psychotic illnesses are given nearly as much education [as other diagnoses] around their illness and around their medications and their options and things like that

While some staff emphasised the importance of education, others felt as though the CRT was not a suitable point of care for educational interventions for service users with psychosis.

> INT: You said doing some education, what does that mean?
> ST03MS: The thing is the education stuff comes later doesn't it. I think.
> INT: I'm not sure.
> ST03MS: Yeah because I think if someone's got quite unwell, you can do some basic grounding work. Just relaxation work, medication work with them, just trying to get them to look after themselves. You can't do any educational work with people until they've got well enough to be able to process that and look back on what's happening for them. You could do some – looking at that sometimes I think in a lot of cases the crisis team is not involved then but the crisis point.

Other staff felt as though there is no formal training for providing psycho-education for psychosis. Rather the ability to educate service users about psychosis is reliant upon individual staff and whether they engage with educational materials.

> ST05FS: …We can provide general psycho-education, but again, we don't have specific training, so normally that would be the individual worker and what they're willing to research and pick up themselves. So, it's not that we've got specific psycho-education tools that we use to give to people and their families, we've not got allocated or specific outlined guidance around what we provide. It would be the worker themselves that would do that research and use that. We use Rethink [information from a mental health charity] or something quite generalised.

This sentiment was echoed further by some respondents who felt as though they were not provided sufficient training in order to deliver informed interventions.

> ST08 I certainly feel like there's little I can offer to someone who's in a psychotic episode, other than monitoring the situation, making sure the risks aren't or are there, obviously checking for medication, making sure that they know that they have someone that they can turn to. But beyond that, I mean if someone asked me to go and see the psychotic person and find a way to actually treat them, I'd have no idea.

Purpose of CRT visits

Both service users and staff highlighted that the purpose of the CRT and of visits were not always clear.

Service users had a mixed understanding of the CRT and the purpose of home visits. Some participants provided a clear explanation of the function of the CRT and their role in gatekeeping hospital admissions, but were not certain about what this meant in practice.

> INT: Did you understand what the team was for at the time?
> SU12FA: I need to say yes and no. I think I did. I knew that they were there because I was in crisis because of their name and I knew that they could see me on a more regular basis than anybody else could and that they were there to – not stop me but support me to not go into hospital, but I didn't quite know what I was meant to say to them or what they could offer me. Was it just a listening ear or was it advice as well or could they refer me to other things?

While CRTs are distinct services and have a specific function, it was evident from the interviews that people experiencing psychotic symptoms did not feel well informed about the role of the CRT.

> SU05F: I'm not going to lie to you, I didn't know what it was all about, I was just so confused. I was really anxious about my studies, so for the crisis team were people who would come and talk to me and give me medication and they were nice. But I didn't know why they were there…

Staff also felt as though the purpose of the CRT may not be clear to service users with psychotic illness

> INT: What do you think the barriers are that people with psychosis can face in accessing the team?
> ST04: Well I think they will have mental health difficulties themselves, their psychotic experience itself, so things like communication, misunderstanding, misinterpreting, what is said in the moment, what the home treatment team are trying to do with them, what they are for, what they are about.

Other staff felt as though this barrier can result in breakdown in communication, the result of which can be awkward interactions

> ST08 It's just quite restricted, I don't feel like there's much we can offer a lot of the time, and I think it can be very confusing for the patient as well, especially if they're lacking insight and they don't really understand kind of why we're there, and we're just turning up and going okay take your meds now. It's not always – it's not often very comfortable for us, and I can only imagine that it's not very comfortable for them.

In terms of interactions with the CRT this perceived lack of purpose resulted in uncomfortable home visits.

> SU11M: They came here a lot of the time but it was a bit embarrassing almost initially sort of… you just kind of sit round going, sort of how are you and you just go, I'm fine. They weren't really good at talking to me, so it got to the point I said… we spoke to save the embarrassed silence, to save them the embarrassed silence you know.

Some staff felt as though communication of information around the purpose of CRT visits, discussed more often and openly throughout a period of care, may help overcome these barriers.

> ST10: I think we do care planning with the individual, so we we'll discuss the purpose of visits then. Perhaps not always as well as we should. I think, yeah, maybe more regular open discussion about what we're offering as a team, could be more focused. I think if we have that discussion at the start of the intervention with somebody, and you're saying to them, 'This is what we can offer. What would you like? This is what I think you need.'…That's generally the first time you meet someone, and then a plan would be agreed. So, as an individual, that's what I would always offer. So that person would have an idea of what the plan was at the start and why we were doing that, but I think probably also then further into the job perhaps I don't always revisit that much and make sure the person understands why I'm there every day or twice a day.

For some service users a lack of clarity around the purpose of CRT visits, led to the perception that they were only carried to meet arbitrary visitation policies and not meeting the needs of the service users.

> SU11M: …You know, one particular person has been going on and banging on about it [crisis plans] and it's like just causing me more stress than it's worth, you know and just wasting time on it. I felt it should just… I don't think we really hit it off, I don't think we really like each other much and it's a sort of box ticking exercise, going through these plans, these crisis plans.
> INT: So did you get them… when you said box ticking, you mean it's just to -
> SU11M: Keep somebody in a job, you know. It's kind of… but the jobs that the people are in, they must feel too, quite frustrated about it because… especially when they meet someone like me who's got that sort of situation. I mean it's really not much use to be honest, apart from just writing a few things down.

> SU03F and a bit kind of, well, what's the actual point of this? It's a bit kind of late in the day for, you know... So it's kind of like, okay, well they're popping in to check on me and it's probably to tick some boxes and that's okay, but it's not necessarily – probably, you know, it doesn't necessarily contribute that much.

Staff recognised this view and highlighted the need to manage the expectations of service users and the limits around the purpose of the CRT.

> ST09: There's quite a few scenarios that people do offer the Crisis team. 'They're crap. They don't help you at all. I'm still not enjoying this...' whatever it is. 'I'm still having this. I'm still this.' Well... OK, I'm not saying someone didn't have a bad experience of a Crisis team but this idea that a mental health professional can come in and fix someone else... Obviously we can try our best to help but it's expectations that we can sort of somehow do something almost magical is not helpful.

Withholding Information

Service users discussed their experience of the CRT, as one where they withheld information. For some, withholding information was associated with the psychotic symptoms they were experiencing.

> SU06FA: …you'll probably be suspicious and paranoid and withhold information and…or not, or just be going on and on about all kinds of things so…and then it will change day to day, sometimes your beliefs change day to day so it must be very difficult to deal with someone, and also to make decisions and task them to make decisions because you don't often make sound decisions you've got to sort of make decisions about people coming to see you or what information you…say mistrustful about that so it must be very difficult for mental health services I think, you know.

Often reasons for withholding information were associated with fear of the impact that the CRT might have for a service user.

SU04F: I never really opened up or let them know what was going on in my head with my kids being taken away, or I might not be able to see them so it kind of made me withhold a lot.

While some service users felt the need to withhold information in order to distance themselves from the CRT, others discussed using these means in order to retain CRT input. Service users were unable to openly communicate needs with the CRT. The impact of this was that they were unable to request respite from CRTs visits, because of fear of losing support, resulting in a sub-optimal experience of care.

SU12FA: …I think sometimes I may have said, like when I said I needed some space, I was not completely saying it because I didn't want them to close [the referral] and I think that made it more unhealthy for me really because that space would have been really healthy.

Staff also felt that psychotic service users commonly withheld information from the CRT.

INT: Do you think people withhold information from you as a mental health professional?
ST09: Without a doubt. [laughs]
INT: How big a thing is that?
ST09: It's incredibly intrusive to be asked what you're thinking, what's going on in your mind and what's happening, and if someone doesn't want to tell me something I totally respect that, and also if people would realise if they were to totally let go, let out what they're really truly thinking, then they wouldn't want to have to be told, 'You're unwell,' because it's very important that this is your own experience which we're talking about and it's important that it's treated with respect.

Some staff felt as though there were reasons specific to psychosis which meant that service users might withhold information – i). the perceptions of others and ii). the potential they might be hospitalised.

ST01FN I suppose going back to the trust thing and the paranoia. And you often find that people are quite guarded about telling you the full ins and outs of their – of what it is that's going on in their mind, with good reason because, you know, most of society would just tell them they're crazy and would feel very uncomfortable with it and not want to talk about it. So a lot of people are quite guarded about disclosing whatever it is that's going on in their minds. Also because they, themselves, fear that they're crazy or worried that you're gonna lock them up or, you know, whatever it is, the men in white coats.

Another member of staff felt as though the threat of hospitalisation and the hospitalisation process may result in service users withholding information.

ST06: So for the people that know that being in mental health services, will not want to or may not want to engage with us because they know what the options are, so

> they know, or at least they think, that we're going – everything we do is coercive to try and get somebody into hospital, so they'll withhold information and not really say the truth, and end up having those thoughts. Because we do support people into hospital, so we can... they know that's one of our options, so it's really, really difficult to sort of work on that rapport with somebody and just say, no we want to keep you out of hospital, that's what we do.

CRT staff felt that on occasion they will withhold information form service users, if they fear service users will respond badly, particularly around the prospect of hospitalisation.

> ST01FS The other scenario I was gonna mention that I've been involved in is where you don't mention that you're considering a Mental Health Act assessment and you can use that, it can also be used manipulatively. And I don't like to think I'm being manipulative, but we are manipulating people by mentioning this whole area of threats of Mental Health Act assessments. If you don't mention it, I've done that deliberately where I've thought the person will just abscond if I mention it, like if we mention Mental Health Act assessment this person's just gonna disappear and then they'll be out on the streets untreated and at higher risk from – vulnerable to other people.

> ST09: I wouldn't tell someone that if the risks outweighed... For example, if I thought that telling someone that might increase the risk to themselves or to someone else, or in some form you need to obviously not do that. But generally, the vast majority of people are incredibly honest and incredibly straight with people and say, 'Look, see us, or this might happen.'

Other staff provided an alternative view, feeling as though transparency and openness around the possible outcomes of treatment is particularly important with a psychotic population.

> INT: Do you ever feel like you withhold information as a professional?
> ST06: I think in the past I have, yeah. In the past when I was less experienced, you kind of think, oh no I need to keep that in the back of my mind as one of the options, but as the more experience I've got, especially in people with psychosis, is that transparency, but in like a holding transparency as well, not saying these are options, and not giving any sort of narrative or explanation to it, but to kind of work together with people. So because that's my mind-set now, I do model that to the team, with openness and transparency and things like that, because if you are withholding – if you are working with somebody that's got the tendency to be paranoid, and you're withholding something, or you change a plan and you've always had this sort of plan, people are not stupid, they do notice.

Some staff felt as though decisions are often made about service users while they are not there, when that should not be the case. Staff also felt as though the focus was too often placed upon symptoms rather than how those symptoms might impact upon the individual. The staff member outlined how they can tend to start withholding information from service users when they begin considering hospitalisation.

ST07: ... we make a lot of decisions in the background about people on very limited information, although we might talk a lot and it sounds like we know a lot, we don't, not really, you know we've only got a tiny little snapshot of someone's life. We need to be keeping that service user up to date with what we're thinking and talking about, but I don't think we do that enough. I think, although it's supposed to be rapid production and working together, I think we go to someone like, right, okay, we will see you tomorrow instead of, let's make this plan together. So, I suppose, I think in terms of crisis work we're good at asking, are you hearing voices, what are they saying, do you think they're real or can you see that they're not going to hurt you. So, I think we're good at asking those questions because that's how we know, we need to ask those questions to identify risk and how that's impacting on that individual. But, I think, in terms of then when hospital might become an idea, do we talk with the person enough about that? I don't think so. I think it tends to be right, I can't work with them anymore, Mental Health Act assessment and off our hands now and that doesn't feel right.

Openness

Despite reports of a dynamic where both service user and staff withhold information from each other. Half of the staff members felt that being open with people with psychotic illness, was an important part of crisis care. One staff member described a change in their approach to place more of an emphasis upon transparency, the result of which means that service users perceive the CRT to have more integrity.

ST06: [service users feel that] you said you weren't going to get us into hospital, you said you weren't going to do that, you were really – and you did, so the next time they come round they say I'm not working with the crisis team, so keeping us at arm's length because we lied, through their perception we lie, and we get people into hospital. So I don't blame people for not wanting to work with us again. Then you try to build up all of that rapport and that trust again, but it can just be dashed really quickly.

Staff discussed openness in letting service users know about concerns about their health, wellbeing and treatment. In some circumstances this could relate to hospitalisation

ST07: I think we just need to be discussing and you've got to be open and honest with someone and say, look, we're worried about you, we're thinking hospital might be good for you at this moment in time, what do you feel about that and what do you think. We might have to still go ahead and make the decision on behalf of that person if we think they're lacking capacity, but there's no harm in telling that person that.
INT: You were talking about hospitalisation.
ST07: I think the worry, or perhaps a reason why we might not talk to someone about potentially hospital being an option is if we think that would then make the person disengage from our services. I think, it's a fine balance sometimes. But, I think if we're thinking of that you need to be open about that.

Another staff member highlighted that it can often be a matter of timing – deciding when to let people know about the likely course of action.

> SU10: I think really open and honest communication from the start should be really important. Try and respect somebody, so, 'Yes, you do have some concerns about your mental health,' whether they fear you're coming from an individual way. You might have concerns about their mental wellbeing but... I think we can say this really honestly as a Crisis team as well, 'We don't want to put you in hospital and we don't want to make your life shit. We want you to carry on and keep your job and keep your health and keep your relationships,' and I suppose be really genuine about that and hope that they are going to agree with that as well.
> INT: Sounds quite firm. So being genuine and upfront about hospitalisation is you approach?
> SU10: Yeah, yeah, absolutely. I think you get a difficult balance between not wanting to put someone off and also not wanting to use that as a threat but sometimes feeling like it's necessary to be real with someone and say, 'This is the situation that we're all in. We're just concerned about your mental health if we don't see some positive changes, or we don't think that you're going to be safe, this will need to happen. Perhaps hospital will be an option.' I suppose it's finding the right words at the right moment to say that.

Theme 3: Features of Psychosis

Both service users and staff discussed psychosis itself as a barrier to crisis care. The theme describes a set of barriers specific to this population and discusses two sub-themes of symptoms and risks.

Symptoms

The majority of staff discussed symptoms of psychosis as a barrier to crisis care. Delusional symptoms were reported to result in a lack of trust and rapport with the CRT. Staff also highlighted that due to the severity of symptoms and risks associated with psychosis, this can lead to staff focussing upon symptoms rather than the individual.

> INT: So are there any sort of barriers that people face, people with psychosis, face in using the crisis teams, do you think?
> ST01FN Yeah, so that thing about trust and rapport is probably harder for them… I suppose, yeah, delusional beliefs can be a barrier, so believing that we're part of some conspiracy. And then I suppose attitudes from the services themselves, so people who might not be thinking of seeing the person as a whole person or might be only seeing them in terms of a diagnosis or in terms of, you know, need to take medication kind of thing. That could be a barrier to somebody who actually wants to have more of an understanding of their difficulties and talk about it.

The concept of seeing people as a set of symptoms, or a diagnosis, was experience by service user participants - resulting in a sense of depersonalisation. This exacerbated the depersonalisation that was already felt to occur in experiencing psychosis. It was felt that a greater focus upon the impact of symptoms for the individual, can help to ameliorate this.

> SU12FA: I think there was a lot of focus on my voices and what they were saying and my delusions and possibly a little bit too much focus on them, forgetting how I was feeling about it and more about checking that the delusions and the hearing voices weren't gonna harm me or anyone in any way. It was a lot about, 'What are they saying?' 'What can you see?' Rather than, 'How did that make you feel? What can you do about it next time?'
> INT: The focus is almost too much on symptoms rather than…
> SU12FA: Yeah, I think it was. I think it's about safety why they did it that way but I think it would have been nice to… 'Okay, well, you see that. That sounds horrible. How does it make you feel?' or something would have been a bit helpful… me being a person rather than a mental health problem and I think sometimes we can lose that we're people first rather than a mental health problem.
> INT: Is that how it felt at times?
> SU12FA: Yeah, it did feel at times that I was losing me anyway because it felt so overwhelming, my mental health, but also a lot of the questions were around the symptoms of my mental health condition rather than, 'Okay, but how do you feel about that? What does that make you think?' rather than, 'What are they saying? What can you see?'

Service users also recognised the barriers that psychotic symptoms can place in engaging with the CRT. Fear of how others view them, and denial of experiences were thought to result in service user's reluctance to be open about their symptoms.

> SU06FA: I think it happens to a lot of people. It's the nature of psychosis, being…having a problem with psychosis because you've got beliefs or delusions or whatever and people say that they're not real but they're real to you so there's that end problem anyway that you have so you might not say things because you're worried about what people might think of you, you know, or you don't trust anyone so it must be very difficult for professionals to talk to people in the first place you know.

All staff felt as though the loss of capacity to make informed decisions was a common symptom of psychosis and played an influential role in providing crisis care for people with psychosis.

> ST03MS: I think the definition of psychosis really is that you lose capacity. A lot of people with capacity and lose touch with reality so it makes it really difficult to work with people, because we need consent and capacity to work with people.

Staff also presented the view that as a CRT cannot provide 24-hour care, the needs of those with psychosis could not be met.

> ST03MS: You can't be with someone all the time. If someone doesn't know what they're doing they can't really be left on their own. It's not really good managing. You wouldn't leave a child on its own would you? If someone's not got the capacity to know what they're doing, and they're really unwell you can't just leave them there. It isn't possible isn't it?

The prominence of capacity as an issue for people with psychosis and the view that community treatment is ethically questionable for those with a psychotic illness, means that hospitalisation is commonly considered for this population.

> ST04: Well, I think in practice, 99 times out of 100, if someone doesn't have mental capacity, as defined by the [Mental Health] Act to consent to treatment at home, then 99 times out of 100 it is more appropriate for that person to have a Mental Health Act Assessment and to either – well you usually go into hospital under the Act or possibly informally, whereby you're constantly checking that the person is willing to go along with that.

Risks

Only staff spoke about risks as a barrier to the provision of crisis care for a psychotic population. Risks were discussed as both risks to service users and to the staff member providing care. The majority of staff felt as though the commonplace risks associated with psychosis were higher than with other diagnoses and were a significant barrier to providing crisis care for this population. Staff conveyed that they prepare to prevent the worst foreseeable outcomes when working with this population, as the outcome is often unpredictable.

> ST03MS: We do a whole process of what we think is likely to happen. What the worst-case scenarios are and what the best-case scenarios are and somewhere in the middle is normally where it goes, but when you're working with psychosis the one thing that you can predict, is that person is probably completely unpredictable because they haven't got capacity you possibly get things a bit messy.

Staff felt as though these heightened risks result in a more cautious approach in providing crisis care to people with psychosis.

> ST07: I don't know. I think the behaviour can be so extreme compared to some other diagnoses I don't know if we panic a bit and go, oh, we can't cope with that, or we know that getting medication into someone as soon as possible has a better outcome. Also, I suppose it's very hard for families and carers to be trying to hold back behaviour and distress and that risk, especially if someone is having thoughts to harm someone else and they're lacking insight into that thought then we can't risk that.

There was some disagreement amongst staff around the way that they should approach the provision of crisis care for people with psychosis. Some staff felt as though hospitalisation

was too readily used, due to perceived risks around treatment in the community. This results in the CRT failing to offer the service users the chance to recover in the community.

> ST02: In this team are people who have been in the Crisis team for a really long time and they have the most experienced clinicians and I guess by that I mean people who have worked in the Crisis service the longest, so kind of dispute whether that means they are more experienced and a lot of those people would be from a nursing background, so there might be the odd person that is maybe a bit more risk averse and maybe feels this person should definitely be in hospital whereas other people might think, "No, I think we can go and treat them." Yeah, there are risks but we need to take a chance because this person deserves that.

In contrast, for other staff, the impact of previous experiences where psychotic service users have committed suicide, has led to the belief that the risk of treating in the community should not be taken.

> ST03: Coming back to risks, if someone is floridly psychotic, if someone doesn't have any support or carers around them and they become psychotic, I think it's really difficult to calm someone down. People don't know what they're doing. Puts them in a very difficult situation doesn't it. We've had – I think there's been, I can think of at least five, particularly males who've killed themselves under care of the crisis team, or when they've been assessed. It's normally been within a week of being assessed as being psychotic and not admitted to hospital and they've died and I've always thought they should have been in bed.

The perception that risks are particularly high when providing crisis care for a psychotic population led to staff feeling fearful around the treatment of those service users. This fear related to individual interactions, which resulted in the rushed provision of care.

> ST02: I guess a lot of people with psychosis that we see have maybe more of a kind of a riskier background; they've maybe been more with a forensic history or they're a bit more unpredictable and you never know quite what you're going to get when you knock on that person's door. Yeah, I've seen people where you knock on the door, they tell you to come in and then they're standing in the corridor in the pitch black and you just think how long have you been standing there and why is it so dark in here? It's something about the atmosphere and your interaction, does that person make you feel on edge? Particularly when you know their history and some of the things they are capable of and you're just like I'm not going to come any further than this entry and check their medication, you're okay, ask a few questions, get out of there.

Other staff described feeling more concerned about someone with psychosis – this obstructs the provision of person centred care, through reliance upon risk focussed plans.

> ST07… Just from the time I've been here, we tend to be probably more concerned about someone with psychosis, but I think we have our set ways of looking after it and we lose that individuality a bit because of that, so I don't really like that. I think

> that's why we pretty much go straight to medication, or the Mental Health Act, or see a psychiatrist. There could be more room for more psycho-social education but it's hard when you've only got up to an hour with someone a day who's hearing all these things that are really upsetting them.

Staff also described fearing the very public ramifications should there be a bad outcome. This can lead to fewer risks being taken and the use of hospitalisation to mitigate the likelihood of a bad outcome.

> ST09: If people go to hospital a lot of the time because of the way the system's worked out, people need to cover themselves. If something terrible happens, if someone dies, or if something bad happens and they were assessed two days before, the papers, people will say, 'Why didn't you put them in hospital?' You've got to pre-empt that so people will sometimes end up in hospital on the premise that something might happen.

Previous, bad experiences of suicide, makes staff take a more risk adverse approach and there is an element of self preservation in decision making.

> ST10: So maybe because we have a series of suicides last year regarding a person with psychosis and it was extremely traumatising for the team. God only knows what it was like for the family but... A year after that, I and other colleagues felt anxious working with people with a similar presentation because we don't want that to happen again. I felt like I can't handle that happening again, and so the care that you give, the support that you give, would be give too much. You're doing everything you can not to have a repeat of that.

Theme 4: Power and control

This theme concerned the power dynamics in the relationship between the two participant groups and the locus of control for service user in relation to CRT staff relationships and at a broader systemic level. The theme of Power and Control related to many of the other themes and sub-themes in this study and presented a series of complex interrelated sub-themes, which were discussed by both service users and staff: Power, pressure and hospitalisation.

Power

Half of staff participants discussed the power dynamic in the relationship between staff and service users as an important consideration in crisis care. Some staff highlighted that power can be used as a clinical tool, used in different ways to suit specific situations. It was felt that in some circumstances power can be used to reassure service users of the ability of the CRT to provide treatment.

> ST06: ...it's from the way that you dress, the way that you carry yourself, the way

> that you explain things, and I want to put the person who needs that as well; sometimes you need that little bit of power, sometimes you don't. Again it's just about openness, communication, so all of those basic things that I think are really important.

However, staff highlighted the importance of awareness of the power imbalance inherent in the CRT staff and service user relationship.

> But the most important thing is what we talk about in the team a lot is actually being aware of the massive power imbalance that we have, so if it's at the front of your mind, you're always making decisions that are not prescriptive and overbearing, and make sure that those are joint decisions as much as they can be.

It was also thought that the use of power to demonstrate authority, can be useful for reassuring families.

> INT: Is it useful to have that professional... you are the professional, you are the expert almost. Is that ever useful or is that not something you really use?
> ST10: I think it's useful for families sometimes. I think for families that are really stressed about a relative's wellbeing. They might want a professional, somebody who they feel is very in control and is very professional to feel, 'Thank goodness you're here. They're going to help my relative.'

The adoption of an authoritative role was commonly discussed by staff in terms of 'prescriptive practice'. This referred to the CRT staff using an assumed authority to outline potential outcomes from CRT input, in order to care for service users.

> ST06: Sometimes we have to be prescriptive, I get that, but as long as you're aware of the power, and aware of the power that we have, we've got all of these things at our disposal which are really big entities aren't they, so we've got mental health act assessments, we've got beds, we've got all of these big scary things, you know, as long as we know about it, we hold it there, then yeah, and I feel comfortable to see them [the crisis team] do that.

Another member of staff described how 'prescriptive practice' is used to explain to service users what care options are available.

> ST05FS: I do, I mean, as a rule whenever I do - I'm quite prescriptive - so whenever I do an assessment I always start by saying, with the crisis team do you have an understanding of what we do, and I explain generally.
> INT: When you say prescriptive what do you mean by that?
> ST05FS: Well, I will say 'well we're in a crisis service, you work with us, do you know what we do? It can look like this, or it can look like this and I'll give a list of what we do and what we've got access to and the best case scenario and worst-case scenario, worst case scenario being hospital admission under the Mental Health Act', but I don't say that in a threatening way.

However, the use of power to portray CRT staff as figures of authority to service users, was not universally supported by staff. Some staff disagreed with the concept of prescriptive practice, feeling as though the notion that service users should defer to CRT staff is disempowering for service users.

> ST08 Oh yeah, very much so, yeah. Personally I don't like the idea that because I'm a mental health professional I have some sort of authority or something; I don't see it that way at all. I'm there to work with the person, not – I don't like prescriptive practice personally, and I'm not a fan of it, so I always try and express things in a way that is like, this is for your own benefit and this is why, rather than, you should do this because we're telling you to do it. But I wouldn't say that's the same for a lot of workers, I think some people are quite prescriptive and they are quite pushy about things, and I don't think that's – personally I don't think that's helpful at all. I know I don't like people telling me what to do.

Other staff felt as though assuming roles, where staff are experts and authorities and service users are unwell and reliant upon staff for their health to improve, can result in unrealistic expectations and perpetuate an unhelpful dynamic.

> ST09: … Sometimes we're built up to being able to solve people's problems when we're just... We were saying about roles before about being a mental health nurse working in the Crisis team, in a sense these roles are unhelpful, because it sets up the dynamic of someone being the unwell person and someone else being the person who can come in and try and fix everything. In certain circumstances that can be helpful but in other circumstances that can also be a real hindrance because we don't have superpowers where we can turn up and solve people's problems.

Service users also discussed the impact of a prescriptive approach from staff – viewing it as forceful and not allowing the service user to be heard. With the threat of hospitalisation used to enforce their direction.

> SU03F Yeah, yeah. Less, and also less forceful, so instead of the kind of directive of you have to do this or you must do that or we want you to –like, they're always kind of projecting their kind of story on you. So their kind of agenda, in a way, that's like we're not comfortable with you doing this, therefore you have to do this otherwise we're gonna take you off and, you know, and do whatever.

Service users responded with a particularly strong negative response when they perceived CRT staff to be acting as in a paternalistic or authoritative way.

> SU11M: … It was like the others, just nagging on about it, it's like just look, I've made my fucking mind up, you know. You're not my mum, you know, you don't know what the situation previously caused, and yeah totally appreciated that.

Again, in contrast to the staff supporting prescriptive practice, others felt as though a levelling of the relationship between staff and service users, is beneficial for service users – championing person-centred care and support service users to view themselves as in

control and capable.

> ST09: I like to tell people actually there's no difference between me and you really. We're all human beings. I could even be psychotic. Who knows? Why make this distinction between carer and someone with psychosis? It's the same as us. They could quite easily provide care to someone if they wanted to and if they were in that mind-set where they probably could do that.

The notion of supporting service users to take back control of their health was deemed by some staff, as central to the provision of crisis care for people with psychosis. Staff highlighted the difference between promoting control and pushing service users to take responsibility for their health.

> ST02: we should probably look at other causes of pain in your eyes and head and maybe go an eye test and a test of your eye health and things like that. You're showing them you're listening to their symptoms and distress but you're saying, "Okay, here's a list of other things we need to explore first of all and if you do some of these things it might give you back a sense of control and it might make you feel like you're taking action and doing something about it."
> INT: What effect do you think giving people control has?
> ST02: I think it's so important. I feel like it's always one of the things I'm trying to bring back to people, is this is your head and this is your body and you have a say as to what goes on in there and I think giving back people that sense of control, surely that's what we're trying to do and I think it's helpful for them to be reminded of that. I think it's much nicer for someone to hear you're giving them back control rather than they need to take responsibility because that could be classed as a criticism.

Service users also emphasised the importance of supporting people with psychosis to take control. They highlighted the pertinence of this approach, for those suffering from an illness that is, in part, defined by a lack of control.

> SU12FA: …There were lots of choices and I felt very much in control of that really which was good. When you're not in control of anything and suddenly then you've got control – okay, got this help where and when am I gonna see them - is kind of helpful.

Pressure

For service users, a power imbalance was embodied in feeling pressurised by CRT staff. Four service users highlighted that they felt that CRT input was invasive, resulting in a sense of pressure. Some service users found felt intimidated by the CRT visit format, which could be overbearing and impersonal – particularly when CRT staff operate in pairs.

> SU03F it's not that great because often they'll [the CRT] come and just sort of hover or they kind of come in twos and [laughs] – and I know that the intention's good and

it's trying to kind of enable that transition back to being at home to be easier. But sometimes it can – even that can feel a bit intrusive

Other service uses described the impact of feeling pressurised during home visits as a barrier to communicating with the CRT. In this case, due to feeling outnumbered and lack of sensitivity to the home environment.

SU08: Well before I was sectioned this time they came to my parents' house where I was and first of all it was two of them who came in so there was two of them and I'm just kind of one and also they didn't close the door or anything so I could hear my parents and because of what was going on in my head, was about my parents, I thought well they can hear me, sorry I can hear them so they must be able to hear me. So, I couldn't open up to the crisis team at all so they just left after like five minutes or something.

Another service user discussed the CRTs engagement strategies as pressuring, when they did not want to see the CRT. The service users discussed feeling pressured to consistently engage with CRT, due to fear of losing support - whereas they believed it would have been beneficial for their wellbeing if they had been allowed some time without CRT input.

SU12FA: They were trying to be supportive which was great but it was kind of like, okay I just need to digest what support you've already given me and I need to breathe for a second and I am still in crisis, don't leave me but I do just need some space and I'll call you.
INT: Did you feel like you tried to get that across or were you not really able at that time or did they not really hear you when you say it?
SU12FA: I did say it a couple of times. I did say, 'I don't want to talk to anybody at the moment. I just need some time.' It probably wasn't as rational and it probably wasn't as clear as I'm saying it now but I feel like I did say, 'Just give me two minutes. Just give me a break a second,' without… 'cause I didn't wanna be rude either 'cause I didn't wanna lose them and lose their support because the support was helpful but I did need just two days of kind of respite.

Staff discussed the use of pressure as a tool to facilitate crisis care. In particular, the expectation for someone to get better and so as to help service users believe they will get better.

ST02: … you sit with them and say, "What do you want to do? What needs to be done? What can you manage? What can you put off another day? What do you want to do? What would you like to achieve? Okay, so we'll do that this time, we'll do that this time and you can have lunch then, and you can do this then." Then you're reminding them of routines, reminding them to eat, have a bath, have a wash and then they go, "Oh, okay, so I might not know what I'm doing in ten years' time but I know what I'm going to do for the rest of the day."
INT: Do you think that adds pressure on people in any way?
ST02: It probably does, yeah [laughs]. I think people feel pressure a lot of the time. You have people say, "I feel guilty for wasting your time. I feel bad all this time and

energy and everybody is trying to do their best to help and I just can't manage it." It is pressure. We do expect people to get better.
INT: Yeah, do you think that's okay or useful sometimes or not?
ST02: I don't know. I kind of think it's a manifestation of hope – and that's another thing - I think we're there to carry that hope and say, "You can get better. You deserve to get better and we'll help you try and find some of the things you might need to do to get there." And then that does put a bit of an expectation on them, because it does require their participation and their input.

Service users valued the notion that CRT staff should help service users to regain control over their life. However, emphasised the importance of not feeling pressured to do so – as the perception of pressure can serve to disempowerment and a lack of control for the service user.

SU06FA: I mean they do talk about everything and if you want to talk about anything they would and they would be straightforward. I got the impression that they would be straightforward and open with you about things. That's what you wanted but they, you know, but they make you feel positive and they make you feel like you can get on with life again.
INT: And what made you feel like that, you know, would you say?
SU06FA: Because they didn't put pressure on; they explained that they're just concerned about how I'm getting on and they were there as my support. Everyone's different and needs different things and I didn't feel pressured at all… they weren't sort of saying oh you know, you've got to do this, you've got to do that, you've got take your meds, you've got to…this might happen again but I'd be like…they didn't sort of say anything that would…I don't know what the right word is really. I mean sometimes I think when you're in hospital you can feel pressured in a way, it makes you a bit defensive, or makes you not say anything because you're worried about saying the wrong thing or you know a lack of control…having a lack of control, people taking over, I think that happens to a lot of people when they're in hospital. So sometimes it makes you a bit cagey you know.

Another service user described the they pressure felt trying to meet the expectations of the CRT, when they do not feel as though they are achievable in their current mental state.

SU03F: a lot of the time I've felt that there's been time pressure in these situations. It's like even when they've said, "Oh, we're coming back on Tuesday morning," and it's been Sunday evening and then, for me, there's this little kind of, it's almost like a bomb waiting to go off, this kind of like countdown of, okay, they're coming back on Tuesday morning.
INT: Really?
SU03F What can I – you know, it's like oh I have to do these things before Tuesday morning so that they think I'm okay, but then actually not actually having the capacity to any of it, so. And some of those things might include jumping on a train and going to a relative that I would feel more safe with. But actually that's sort of a slightly impossible thing to do when you're in a difficult state.
INT: So you're feeling – almost feel like you're…

> SU03F Well, things like, oh, well, maybe I could at least have a bath before they come back and then the time's ticking, ticking and ticking. And like, oh, they're coming in ten minutes so I need to – and then like, you know [laughs].

For other service users feeling pressurised directly impacted upon their experience of psychotic symptoms. In one example, pressure from the CRT to engage with the service, fed into the paranoid symptoms of psychosis. A desire for space was interpreted by the CRT as a symptom of their psychosis, when the service users did not perceive it as such.

> SU12FA: I think the hardest part was when I felt I needed space. When I thought okay right now there's too much going on, I'm seeing too many people or even just life feels like it's getting on top of me and actually I just need some space. I just need a couple of days of quiet. That was quite hard 'cause they thought that that was me declining again and I said, 'No I just need some space. I just need some quiet. I don't want my phone ringing all the time and I don't want to see anybody right now. I just need to sit still for a bit.' I think because they thought that was me declining they would do more. They would ring more. They would knock on the door more and send notes through my door and stuff and that was really stressful because I think it was at the same time that I was having a hallucination that people were following me so not only did I have these people that I believed were following me I also had the crisis team kind of, not after me, but it felt like that at some stages. I did feel completely overwhelmed at one point and just thought actually I can't communicate how I'm feeling every day. That's too much for me. It's just completely not what I'm used to. I think it was quite hard to get them to understand that I wasn't declining and it wasn't my mental health talking. It was me saying I just need a little bit of time.

This was clearly contrasted in the views of some staff, who described those with psychosis as less likely to engage due their diagnosis.

> ST10: Perhaps the main challenges of working with psychosis would be they're often people who don't at that time want to work with our service, so engagement is often more difficult than with somebody with that diagnosis with those difficulties than it might be with people who are perhaps reaching out for help, who recognise their own distress and their need for help. I think that's less prevalent in people that are psychotic.

Hospitalisation

Often discussions of power and control related to hospitalisation. Both staff and service users understood hospitalisation as reducing a service user's control over their health and treatment. Service users discussed the pressure felt to demonstrate sufficient wellness to the CRT, due to fear of potential outcomes, such as hospitalisation.

> SU03F I think in the situations that I've experienced there has been a pressure of kind of having to present in a certain way in order to be kind of let off or to pass

> some kind of perceived approval of, oh yeah, well they're – so – 'cause I think that ultimately the fear is being hospitalised, like if you don't pass, you know.

Another service user described an experience where they felt that despite being in need of crisis team input, they did not qualify for CRT input due to policies around only visiting known service users, resulted in hospitalisation.

> SU14M: Yeah. I have a quite interesting lead up to my admission. I called the Crisis Team I'm not sure how many times, possibly five times over eight to ten weeks. I called them in distress. I told them I was in crisis. I told them that I had mental health history. I told them that my relationship with my partner was deteriorating. I was arguing with her or shouting at her. I wasn't sleeping properly. At no point did they ever offer to visit themselves after any of those phone calls. That at the time was what I needed. To be honest I think I genuinely could have avoided hospital admission if I'd got more face to face support by the crisis services and they have recognised it themselves and their arguments for why I didn't get that support at the time was I wasn't extremely suicidal. I wasn't fully on their list as an outpatient. My name wasn't completely known to them.

Staff discussed the pressures that a potential admission into inpatient psychiatric services places upon service users – especially so, for those with prior experience of psychiatric hospitalisation. A Mental Health Act (MHA) assessment is the process by which it is determined whether a service user has the capacity to make decision about their care. A possible outcome of a MHA assessment is compulsory hospitalisation and treatment – compulsory treatment in the case of psychosis, will likely mean administration of antipsychotic medication.

Staff discussed the power imbalance that exists in the threat of hospitalisation and the pressure to comply with CRT treatment decisions, that this can place on service users.

> ST01FN They might not realise that me threatening them with a Mental Health Act assessment is probably, or potentially, a deprivation of their liberty under the Mental Capacity Act. Or they – a lot of people would, a lot of people say you've got no right to force me to take medication, I'm not gonna take it. But somebody who's vulnerable and probably somebody who's been in hospital before and knows what it's like to be in hospital might feel particularly threatened by that. They might feel I've got all the power in that scenario, I've got the power to call out AMHPs [approved mental health professionals] and say, "Look, this person needs to be in hospital". And I have got a lot of power in that scenario.

It was felt that this pressure and power imbalance was greater for people with psychosis, who due to being misunderstood and thought to be unable to defend themselves, where seen as an especially vulnerable group of service users.

> ST01FN People with psychosis tend to be really vulnerable. And, of course, everyone we see is vulnerable in their own ways, but I think somehow I just have a sense that people with psychosis are more vulnerable, more misunderstood.

INT: What do you mean by vulnerable?
ST01FN I suppose I mean vulnerable as being misunderstood or manipulated or attacked, you know, or treated against their will or accused of things that they can't defend themselves against. Vulnerable in all sorts of different ways and when services play in to that it's a double whammy.
INT: What do you mean by play in to that?
ST01FN Like if the person's already disempowered by the fact that they're psychotic and we then come along and manipulate them or coerce them, then we're doubly disempowering them.

This power imbalance was also expressed by service users, who explained that the threat of hospitalisation can act as a barrier, as it will likely evoke a negative reaction to the CRT.

SU03F Yeah, well it is, it's a big threat. If someone's got that power over you to actually section you and then restrain you and then basically take away your freedom, it's like, well, that's massive power to have over an individual. And no wonder a lot of people, when they're faced with that, do get aggressive and defensive and angry.

Staff also recognised the impact that compulsory psychiatric hospitalisation can have for service users. For some staff, a service user's prior experience of hospitalisation predicted their willingness to engage and work with the CRT.

INT: Is there anything that you would say predicts whether someone is or isn't receptive?
ST07: I think, maybe based on their past experience of working with a crisis team, or mental health services in general if they're just been put in hospital. So, if they've been sectioned before then they might be warier and don't want to get involved.

The views of service users supported the notion that prior hospitalisation negatively impacted upon their relationship with the CRT and only spoke about hospitalisation in a negative way. For some the process of hospitalisation amounted to a rejection of an individual and resulted in the service user believing that the CRT are not on their side.

SU03F Yeah, it almost feels like well actually no one's on my side 'cause they all want me to – they all want to shovel me away somewhere that's gonna sort of contain the thing rather than actually allowing it to be what it is, that sense of at what point are we accepted?

Service users felt CRT staff should experience working on mental health wards, so that they can that they can better understand the impact of an admission for service users.

SU08: Maybe I don't know how many people in the crisis team have had experience on wards or fairly, like given like a week going into a psychiatric hospital to kind of see what it's like and maybe then to understand why someone would be so scared about going into hospital and why it's not kind of a good protective safe place for, you know, everyone or…

The reluctance of service users to work with the CRT, resulted in a tension between ensuring the safety of service users and persuading service users to comply with treatment. Half of staff discussed this tension as a particularly difficult part of providing crisis care for a psychotic population. As gatekeepers for hospital admission, staff know that hospitalisation may be required for people using the CRT. The prospect of hospitalisation was used to encourage compliance with treatment and this dynamic was highlighted by staff as particularly complex.

> ST01FN I think with psychosis, this thing of telling people they have to take medication otherwise we're gonna call the Mental Health Act assessment is really tricky, because often that is actually the reality, that we think that their psychosis won't be treated, the risks won't come down unless they do take some medication.

This scenario is further complicated when staff cannot be sure service users are complying with treatment – where through monitoring medication compliance to attempt to assure that a service user avoids compulsory hospitalisation, staff disempower service users through unintended coercion.

> ST01FN But the grey area is when they sort of want you to go away so they say, "Yeah, all right, I'll take it, leave me alone". And we then don't believe they are taking it or things don't change and it's then very hard to – then you get to the scenario where we say, "Well, look, is it all right if we watch you take it?" Which already feels quite uncomfortable, wanting to empower people rather than coerce them.

Staff identified the balance between coercion and informing service users of likely outcomes, as a difficult aspect of providing crisis care for a psychotic population - with the delivery of information being particularly important. Staff also described a divergence of perspectives between some CRT staff. Some CRT staff were perceived to hold unrealistic views around the role of the CRT and hospitalisation – where they understand the role as one that keeps service users out of hospital, rather than necessary part of psychiatric care and the best course of treatment for service users in some circumstances.

> ST04: Yeah, it is really difficult, really difficult, really contentious [motivating medication compliance through avoiding hospitalisation], because the reality is… I mean I think it is partly in attitude and behaviour and language, you know, how you communicate it. But the reality is, we are kind of governmental custodians, aren't we?
> INT: It sounds a bit of a conflicting thing, as if to say you are a government custodian, and you're also providing care and I suppose it's a bit of a mismatch in terms of the roles, perhaps?
> ST04: Well I say that because that's factually true, but I think the more that staff are aware of that the better. Because I think I've seen some staff, in the past, who think, and maybe that's less these days, I'm not sure, but in the past people have thought, "Oh yeah, we're the good guys, we keep people out of hospital." But the

> reality is, no, you're still part of that service and system as a whole, nationally, that can end up with someone being in seclusion in PICU [psychiatric intensive care unit].

Other staff felt as though they are morally obligated to inform service users about the likelihood of a hospital admission and how this relates compliance with medication.

> ST10: Very difficult. I think it presents quite a difficult moral dilemma as well because I suppose the reality is for a lot of people is if they engage with us and they don't agree to some of the interventions we feel are appropriate, as in we the mental health service, they probably will end up in hospital and being medicated against their will. So, no, it feels to me like we're doing them the right thing by telling them that. We're giving them the option then to... Although it's not a great choice, it doesn't have a great amount of choice in it but there's still some choice. We work with the Mental Act and so ultimately that will be used by key professionals in order to safeguard individuals who are at risk so, yeah, it's difficult.

CHAPTER 8 - DISCUSSION

This chapter provides a summary of the four main themes and discusses their relationship to each other. The findings of the study are discussed in relation to the previously published literature, and the novel contribution made to the evidence base. Finally, strengths and limitations are discussed and a series of recommendations made for clinical practice.

This study examined the barriers and facilitators to the provision of crisis care for people with psychosis and successfully recruited participants to address the research question. This research examined the views of service users and staff as the major stakeholders in the process of crisis management.

The results highlighted needs i). specific to the clinical population in question – particularly in the interaction of the symptoms and risks of psychosis, with clinical relationships, communication and hospitalisation and ii). at this unique point of care – as a critical time of robust risk management and the intrinsic link between the CRT and hospitalisation. Both sets of participants highlighted a tension between the needs of service users with psychotic illness and the ability of the CRT to meet these needs. This tension underpinned many of the barriers that were discussed.

Main findings

The four emergent themes of Relationships, Communication, Features of Psychosis and Control / Power are now discussed.

Relationships

The importance of the service user and staff relationship, in providing crisis care to people with psychotic illness, was emphasised by both groups of participants. There was agreement between groups around what constitutes a positive relationship and the impact of this dynamic, as a facilitator to crisis care. While this concordance showed a shared understanding between participant groups, service users reported instances where they had not experienced relationships they considered to be empathetic, have good rapport, or continuity of care, which acted as a barrier to crisis care. This suggests that despite sharing the same understanding of positive clinical relationship, barriers to fostering a positive service user / CRT staff relationship exist. Some of these barriers are reflected in the later discussed themes of Communication, Features of Psychosis and Power and Control.

A number of service users discussed valuing their relationship with the CRT, when they perceived staff to be ‘friend-like’. Meanwhile in contrast to this, some CRT staff paid specific mention to this perception, discussing the need to clearly delineate between serving as a friend and as a professional. This is certainly part of a larger debate around the limits of clinical relationships, in mental health particularly, and is not limited to people with psychosis, or CRTs. However, it is clear that this balance is particularly difficult at the point

of crisis care and for a psychotic population, acting as a barrier to crisis care for those with psychosis.

Staff participants highlighted the CRT's role as government custodians, pointing to the function of gatekeeping inpatient psychiatric admissions. Hospitalisation is mainly discussed as part of the theme concerning power and control, however, the impact of this integral, mandated function of the CRT upon the staff and service user relationship, is particularly pronounced and a substantial barrier to developing relationships that facilitate the provision of care. Some staff felt as though providing short term care, that may result in hospitalisation, inhibited their ability to offer therapeutic support to service users.

A minority of staff spoke about fatigue at times acting as a barrier to full investment in an empathetic relationship with service users. Meanwhile, staff also discussed the need to be able to share in a service user's anxieties, so as to develop a trusting relationship. Psychosis and risks are discussed later, however, those with psychotic illness were viewed by staff as a particularly high risk population, to both themselves and to CRT staff. CRT staff discussed the difficulty in maintaining emotional supporting for service users displaying high risk behaviours and high levels of emotional distress, which acted as a barrier. An important facilitator highlighted in the results, is the value of staff 'actively listening' to service users. This helped develop rapport and was perceived to demonstrate empathy.

Where CRTs did not meet service user expectation around relationships, staff were seen to be impenetrable. Where staff failed to provide active listening and an empathetic response, service users did not feel as though they experienced personalised care. Feeding into this perception, staff discussed having insufficient resource to spend time providing support with general symptoms associated with psychotic illness, such as depression – fuelling the perceptions of service users that they are not being listened to.

Staff discussed the nature of crisis care as short term and with 24-hour provision, hampering their ability to provide continuity of care. The impact of a lack of continuity care was particularly marked, in a population where symptoms are commonly ones of paranoia and distrust.

Communication

The theme of communication arose as a prominent theme for both service users and staff. There was concordance within the service user group, that the provision of information about psychosis, the CRT, or other available support - whether written or delivered verbally by staff - was a facilitator to crisis care for this population. A number of service users stated the desire for more of these types of information.

The views of staff participants were mixed. Some staff expressed the view that during the delivery of crisis care, it was not a suitable time to provide information about psychosis, for service users - which should be provided later, after a crisis has subsided. This conflicted with the views of service users and other CRT staff. For service users, information and knowledge about their diagnosis and experience, acted as a mode to increase the individual's power or control over the situation by improving their understanding and self-

efficacy. Some staff did not view the provision of information as related to control and did not associate the lack of control innate to the experience of acute psychosis with such interventions. This divergence in understanding between participant groups acted as a barrier to the provision of crisis care for people with psychosis. Meanwhile, the timely provision of information was a facilitator.

Interestingly, there was a good degree of concordance between staff and service users, that CRT visits sometimes lacked a clear purpose. For some staff this related to a perceived shortage of skills and confidence in delivering interventions, specifically for people with psychosis. Both groups of participants identified this as a barrier that can result in frustration, or unrealistic expectations and impact upon relationships.

Of particular note, there was concordance between service users and staff that both parties withhold information from each other. Both service users and CRT staff described the nature of psychosis – where symptoms include paranoia, delusional beliefs and distrust - and the potential ramifications that may arise from CRT involvement - such as hospitalisation - as amplifying this dynamic.

Service users were fearful of both being deemed too unwell to provide care for their children and the potential for hospitalisation. The potential impact of CRT involvement is therefore substantial for individuals using the service and the threat of hospitalisation and the consequences of, impact upon the relationship between service users and staff and act as a barrier to care. The resultant withholding of information impacts upon the power dynamic between service users and CRT staff, prohibiting service user participation in shared decision making in care.

Staff participants spoke about the need to be open with service users about the possibility of hospitalisation as a treatment option. Staff described openness as beneficial to the long term relationship between service users and the CRT, by increasing trust, ensuring that expectations of outcomes are realistic and enabling the provision of person centred care. Staff felt as though being perceived to be consistent and delivering on their word, would help build a trusting relationship with service users.

Features of Psychosis

Service users and staff both reported symptoms of psychosis creating challenges for the delivery of crisis care. For service users, concerns about sharing the extent to which they were unwell, resulted in reluctance to engage with the CRT. Both sets of participants also agreed that sometimes CRT staff could focus too greatly upon the symptoms of psychosis, rather than the impact of the symptoms for the individual. This again resulted a sense of depersonalised care for the service user and highlighted a pronounced need for an approach that considers a range of biological, social and psychological needs, rather than a purely biomedical focus upon symptoms. What is referred to, as a biopsychosocial approach (Engel, 1980).

Some staff viewed the severity of acute psychosis as a barrier to the provision of crisis care, believing that individuals experiencing such an episode would require 24-hour care and

beyond that which could be conceivably offered by a CRT. This perspective is particularly notable, as the suggestion is that people experiencing acute psychosis should be treated in an inpatient environment and that the CRTs role is only to assess and admit such individuals into hospital. This diverged from the views of service users, who stated a clear preference to be treated by the CRT, in the community and were often fearful of hospitalisation. This again highlights the tension between the expectations of service users and the ability of the CRT to meet them. However, this view was not held by all staff and represents a further divergence in perspectives. This acts a prominent barrier to the provision of crisis care for people with psychosis.

Only CRT staff discussed the risks associated with psychosis as a barrier to care - risks such as physical harm to service users, or CRT staff. In contrast, service users did not highlight risks as impacting upon the provision of crisis care. This suggests differing perceptions for the two participant groups and a lack of interaction around these concerns. A tension exists between managing risk, and providing person centred care. Doubtlessly this dynamic is further compounded by the short term nature of crisis care and the lack of continuity of care, resulting from 24-hour CRT provision.

For staff, people with psychosis were viewed as particularly high risk, which impacted upon decisions about care and the staff / service user relationship. Staff described themselves as more cautious, or risk adverse in their approach and more likely to use hospitalisation. Staff described instances where clinical interactions were rushed due to fears around their own safety.

Staff perceptions of heightened risks, feed into the tension between expectations of service users and the ability of the CRT to deliver on those expectations. In turn, this impacts upon the relationship between service users and staff and the extent that they are able to openly communicate and acts as a substantial barrier to the provision of crisis care for people with psychosis.

Control and Power

Both service users and staff discussed the power dynamics in the relationship between the two participant groups and the locus of control - whether control is perceived to be held by the service user or imposed by external agency - for service users in their relationship with CRT staff and at a broader systemic level. A lack of control arose as an important part of experiencing acute psychosis. Needs relating to control, impacted upon relationships with CRT staff and upon communication between the two participant groups. Service users described sensitivity to their sense of control in interactions CRT staff and valued instances where the CRT supported them to regain control. Furthermore, the role of the CRT as gatekeepers for inpatient admission, imposes the potential threat of involuntary hospitalisation upon service users. This threat is one to service users' control, where decisions around treatment are taken away. The impact of the dynamics of power and control, often acted as a barrier to the provision of crisis care for people with psychosis, impeding clinical relationships and resulting in reluctance to engage with the CRT.

Sub-themes of Power, Pressure and Hospitalisation were identified and commonly related to the other themes in this analysis.

There was a marked divergence of views within this theme, including within staff perspectives. The basis of this divergence was around the use of power and pressure, as tools that CRT staff might use to obtain desired service users behaviours and outcomes. This emerged as a debate around the adoption of 'prescriptive practice', which was described as a set of CRT staff practices, involving the use of power and authority to reassure and support service users.

However, some participants described experiencing negative use of prescriptive practice. Some staff described the adoption of an authoritative role as a method that reduces control for service users. Service users who had negative experiences of the use of authority, described it as detrimental to their relationships with CRT staff and as a result, to the communication between the two groups. Service users unanimously described a preference for a clinical approach that increases an individual's control over their own health and treatment. Of interest, the majority of staff discussed prescriptive practice as a personal clinical style, rather than a tool to be used only when necessary.

Service users discussed at times feeling pressurised by the CRT and identified this as diminishing their control and as detrimental to their health - some felt as though the pressure to engage resulted in the worsening of symptoms. This diverged with the views of some staff who felt that pressure can be used as a means by which to help service users regain control.

The perspectives of service users and staff largely converged around hospitalisation, with both participant groups understanding the experience of hospitalisation as a negative experience for service users. Service users wanted treatment in the community rather than inpatient admission. However, this perspective contrasted with the views of some staff around risk, who expressed views that people experiencing acute psychotic illness cannot generally not be treated in the community. This was a clear area where the expectations of service users were different to those of some staff. While hospitalisation is necessary in some cases, differing expectations around the thresholds for admission acted as a clear barrier to the provision of crisis care, impeding upon good clinical relationships.

Staff participants discussed the unintentional coercion of service users, through the threat of hospitalisation. They struggled with the need to fully inform service users of the potential outcome of hospitalisation, without it being viewed as a threat. Staff expressed discomfort with this dynamic, feeling as though it impacted upon the service user individually, as a deprivation of their liberty and upon the relationship between the two participant groups. Service users reported feeling threatened by the possibility of hospitalisation and the perceived imposition of the CRTs agenda upon them. This clearly impacted upon the service user / staff relationship. When thought about in relation to the participant groups withholding information from one another, there appears a fine balance between properly informing service users of potential outcomes relating to hospitalisation and service users feeling pressurised and threatened by that information.

Main findings in relation to current literature

Previous research has not directly examined the barriers and facilitators to the provision of crisis care for people with psychosis. As such, supporting evidence was only found with i). other qualitative studies that examined the provision of care more broadly (not concerning CRTs) for people with psychosis, and ii). with qualitative studies concerning the provision of crisis care, but not specifically for people with psychotic illness. Some findings in this study are novel and have not been reported in the previously published literature.

Relationships

Many of the positive experiences described by service user participants in my study, concerned the relationship between service users and staff. This supports the findings from previous studies. A qualitative study of 36 service users, who had used a CRT in the East Midland UK (Ferguson et al., 2010), examined the factors that are influential to the successful resolution of crisis. The study concluded that from the perspective of the service user, the quality of the staff / service user relationship determines the success of the intervention - In particular, themes concerned being enabled to feel accepted and understood. These notions reinforce the findings of my study where empathy and active listening were highlighted by participants as facilitators to the provision of crisis care. The comparable study (Ferguson et al., 2010) did not use diagnosis as an eligibility criterion, as such the findings of my study suggest that, in terms of relationships, the needs of those with psychosis are in line with those of other mental health diagnoses, at the point of crisis care. However, I additionally found that these needs are heightened for those with psychotic illness, with both service service users and staff participants considering symptoms of psychosis to provide additional barriers to good relationships.

A focus group study of 12 participants with a psychotic illness, who had used an early intervention for psychosis service (O'Toole et al., 2004), examined the experiences of participants, who were asked to highlight the aspects of care that they viewed as key elements to recovery. The 'human' approach was found to be key to the recovery process – referring to the need for empathy, support and personalised experience. This supports the findings of my study, where empathy and the skill of active listening were understood by both service users and staff as central to providing crisis care for people with psychosis. O'Toole's study (O'Toole et al., 2004) concerned the perspectives of those with psychosis, using an Early Intervention for Psychosis Team. This suggests that the service user and staff relationship is important to those with psychosis, regardless of point of care and the findings from this study support this broader understanding in the literature. However, the CRT's role as inpatient gatekeepers and supporting those experiencing a crisis and therefore more likely acute symptoms, is different to that of Early Intervention for Psychosis Team - which offer long term, non-acute support, for people experiencing a first episode of psychosis and usually below the age of 35. In my study, service users described feeing threatened by the possibility of hospitalisation, with CRT staff also cognisant of this perception. This highlights the barriers that specifically CRT staff face in both conveying the possible outcome of hospitalisation, while maintaining an empathetic relationship with

service users. My study found that active listening and openness around the possibility off hospitalisation, may be used to help overcome this barrier.

In my study, negative experiences of relationships were discussed by service users as barriers to crisis care – where a lack of empathy, or not being listened to contributed to this view. Similar findings were highlighted in the literature (Ferguson et al., 2010), where the CRT staff response resulted in service users feeling misunderstood, ignored, unsafe, vulnerable, anxious, or judged, were considered to be barriers to the success of therapeutic intervention. Again, this supports the findings of my study and suggests parallels between the experiences of those with psychotic illness and the broader population of service users that use crisis care, in terms of relationships.

In my study, continuity of care and developing rapport with CRT staff were discussed by service users and staff. The number of staff seen by a service user was discussed as a barrier to successful crisis care, with a lack of continuity and the need to repeat information cited as particular issues. These results support previous research findings that pressurised services resulting in high numbers of staff visiting a single service user, act as a barrier to care. A qualitative study that interviewed ten non-diagnosis specific service user participants (Carpenter & Tracy, 2015), found that constantly changing staff was considered to be an unhelpful feature of crisis care. The findings from my study suggest that the needs of those with psychosis are in line with those with other mental health diagnoses at the point of crisis care. However, the findings from this research that both service service users and staff participants considered symptoms of psychosis to provide additional barriers to good relationships, suggests that needs around continuity of care are heightened for this population.

Features of Psychosis

In my research, features of psychosis were highlighted as a barrier to the provision of crisis care, suggesting the need for specialised provision for this population. This supports findings in the existing literature. A qualitative study of 21 service users with psychosis and nine carers, examined help seeking behaviour for first episode patients (Tanskanen et al., 2011). The study found that symptoms of psychosis were thought to impede the decision to seek and engage with care – in particular around recognising problems as psychosis, which often resulted in help not being sought until crisis point. My study supports these findings and suggests further that symptoms of psychosis can act a barrier to care beyond first episode.

Two previous studies (M. Coffey & Hewitt, 2008; M. Coffey et al., 2004) examined service user preference of clinical response to hearing voices. In contrast to my research, the aforementioned studies found that services users want clinical staff to focus upon the content of voices. Whereas, my study highlighted that CRT staff focus too greatly upon the content of voices, rather than the impact of voices for the service user. This resulted in the sense that the CRT staff were not concerned for the individual and too focussed upon risks – failing to provide person centred care. This points to a variation in needs at different points of care. The two previous studies (M. Coffey & Hewitt, 2008; M. Coffey et al., 2004) examined the preferences of service users using Community Mental Health Teams (CMHTs), while this research was conducted at the point acute care, where those with psychotic

illness are more likely to be experiencing acute symptoms. My research highlights the need to address the emotional impact of psychotic symptoms upon the individual, at the point of acute care using a biopsychosocial approach.

Addition to the literature

New findings are discussed in my study, that have not been addressed in previously published research, making a novel contribution to the evidence base.

Relationships

The existing published literature highlights relationships as a key barrier or facilitator in the provision of crisis care and for service users with psychosis generally, at multiple points of care. In particular, finding the service user and CRT staff relationship to determine the overall success of the intervention. Through the interrelation of themes, my study contributes a novel, fine grained understanding of the systemic and diagnosis specific barriers to the fostering of positive clinical relationships – for example, barriers such as perceived high risk to self or others, specifically associated with psychosis, or the gatekeeping function of the CRT. While previously published evidence notes the importance of relationships, my study provides understanding of why good relationships are not always delivered, along with considerations that might facilitate good relationships.

Communication

My study makes an important contribution to the evidence base with the theme of communication. Interviews highlighted i). the importance of information, knowledge and education for service users, as facilitators to the provision of crisis care for people with psychosis and ii). the understanding of the value of such interventions, as means of increasing control for those experiencing acute psychosis. A strong service user preference for interventions at the point of crisis, concerning i). information, knowledge and education about psychosis and ii). available support and their experience, was at odds with the views of some staff. These staff questioned whether the CRT was best placed to deliver such interventions, due to the perceived inability for those experiencing acute psychosis, to retain information and the need for concerted focus upon risks. My research highlights the need to reconsider this perspective.

My study highlighted that both service users and staff felt there was often a lack of purpose with CRT home visits for people with psychosis. For staff, this related to a lack of confidence to deliver crisis interventions for a psychotic population. My research highlights an apparent gap in CRT staff knowledge and the range of interventions available for CRTs, aimed at people with psychosis.

Highlighting the withholding of information between service users and CRT staff makes an important contribution to the evidence base, demonstrating the complexities of the relationship between the two groups. Withholding of information acts as barrier to the provision of crisis care for people with psychosis, through i). preventing good relationships, ii). hindering communication, iii). feeding into the distrust commonly inerrant to the

experience of psychosis and iv). in diminishing control for service users. It is of most note that CRT staff withheld information from service users, often in relation to the possibility of hospitalisation and in order to retain service user engagement with the CRT.

Symptoms of psychosis

My research contributes to the evidence base through highlighting a tension in participant perspectives around risk thresholds for providing crisis care for people with psychosis. Some staff felt as though the needs of those experiencing acute psychosis are too great for the CRT, with hospitalisation most often the best course of action. Whereas, other staff felt as though service users would benefit with a less risk-adverse approach. Service users also expressed the desire to avoid hospitalisation and receive treatment in the community. It is in this divergence of views that my study contributes to current understanding and highlights the need to align stakeholder views around the thresholds for the delivery of CRT care. In doing so, this would ensure a continuity of experience for service users and as such, set common expectations around the use of CRTs. This current mismatch of expectations in relation to CRT thresholds for treatment acts a barrier to the provision of crisis care for people with psychosis, impacting upon the relationship between service users and staff and resulting in a divided view between staff around the appropriate pathway for care.

The emphasis upon risks and symptoms by CRT staff were described as impacting upon relationships and communications between service users and staff and a barrier to the provision of crisis care for people with psychosis. This resulted in a perceived lack of person centred care and contributes to the literature through highlighting the need for a biopsychosocial approach at this point of care, where at times the nature of psychosis can focus CRT staff too greatly upon symptoms.

Power and Control

Previously published research has not highlighted power dynamics and the locus of control as a barrier or facilitator in the provision of crisis care for people with psychosis. My study contributed to the literature through demonstrating a divergence in service user and staff perspectives and experiences, concerning the use of authority and pressure as clinical tools. In doing so, my study highlighted the need for careful examination of the application of approaches for people with psychosis using a CRT. Unhelpful experiences of the use of authority by CRT staff in clinical interactions were viewed as barriers to the provision of crisis care for people with psychosis, impacting upon service users' control and power - inhibiting their ability to take ownership of their own wellbeing and perpetuating the loss of control inerrant to the experience of acute psychosis. My study further contributes to the literature by highlighting systemic power imbalance for service users, inherent to the function of the CRT, as gatekeepers to compulsory inpatient admissions. This points to the heightened need for CRTs to carefully consider the role of pressure, authority and power and control, for a psychotic population, as barriers and facilitators to the provision of crisis care.

Strengths and Limitations

Overall the study was successful in achieving its aims. I will now discuss the strengths and limitations of the study.

Location

To ensure a range of views, staff and service users were recruited from three separate CRTs within Bristol. However, the study was conducted in a single city and there is substantial variation in the delivery of CRTs across the UK (Lloyd-Evans et al., 2018). As such, the experience of those using Bristol crisis services, may vary substantially to those elsewhere in the UK, which should be considered when interpreting these findings. Future research might develop these findings further with the views of service users from a mixture of urban, suburban and rural locations, so as to confirm generalisability across a range of settings, where the delivery of services often differ.

Sampling

The sample for this study was of sufficient size to achieve data saturation for both participant groups and as such was a strength. 11.5% of potentially eligible service users who were admitted to Bristol CRTs case load, over the study recruitment period, participated in the study. In a study examining the proportion of patients with psychosis willing to be contacted about research, 13.5% of potential participants agreed to be contacted about future research (the proportion of that 13.5% that went on to participate in research is unknown). Comparing the 11.5% conversion rate of this study, with the 13.5% who stated that they may take part in future research, reflects favourably upon the recruitment methodology adopted in this work – as it is highly likely that a substantial proportion of those who are open to take part in research, would not go on to participate (Patel et al., 2017). While the study recruitment conversion rate was relatively high, it is still a minority of service users with psychosis using Bristol crisis services over the study period, who participated in the study. It is not possible to assess the exact impact of this. Potential impact may have been better assessed through demographic comparison of those who participated in the study, with the overall demographics of those with psychosis using the CRTs. Similarly, comparison in terms of referral routes and health services used, proceeding and following a period of crisis care, would have provided useful analysis to understand the representativeness of the study findings. The study required clinical staff approval of eligibility of service user participants and for staff members to make the initial approach of service user participants. As such, it is likely that service users with the most severe psychotic experiences were not approached about the study, due to concerns about their risk or lack of capacity to consent to take part in the research. This more severely unwell population, may have different needs to those that participated in the study, which will not have been reflected in this work. However, efforts were made to ameliorate the impact of this, through a systematic approach to screening participants and engagement with clinical staff around the application of the eligibility criteria. Furthermore, risks and capacity to consent to take part in the study were considered to be transient and while initially an individual may have been excluded from participation, clinical staff were prompted to reassess eligibility periodically.

It is also likely that the study failed to recruit those most reluctant to engage with services – some service users have contact with CRTs, however disengage with the service as soon as possible. Similarly, those who are the hardest to reach – for example those with no fixed abode, or without means of communication – could not participate in this study. The implications of this are that conclusions of this study should be interpreted accordingly, with further consideration around delivering crisis care for those in the most severe stages of illness, or who are particularly difficult to engage.

Diversity

I used a purposeful sampling methodology, with the aim of ensuring diversity in study participants, for both service users and staff.

A diverse range of service user participants were interviewed in relation to age, with the youngest 24 and the oldest 60 years. However, there may be additional barriers and facilitators to successful crisis care for those aged above 60, where multiple health considerations are more likely – such as mobility, physical health issues, loneliness, dementia and neurodegenerative diseases. Similarly, the youngest adults are likely to have additional social considerations and pressures.

Nine service user participants were female and six male and six staff participants were female and four male, representing a good split between the sexes.

There was relatively little diversity in terms of ethnicity, with the majority of service user and staff participants White-British. Of particular note, no service user participants of black African or Caribbean ethnicity were recruited, while the inequalities that exist for this group in terms of mental health in the UK, are well documented (Kirkbride et al., 2012; Mann et al., 2014). This is potentially an important view missed from this study. Similarly, we were unable to interview other ethnic groups and issues such as language and cultural barriers were not investigated.

Implications for Clinical Practice

A number of clinical recommendations can be drawn from the findings of this study.

Recommendation 1 **– To avoid unrealistic expectations, CRTs should manage the expectations of service users with psychosis around the limits of clinical relationships –** Particularly in relation to the role of the CRT in hospital admissions. The optimum timing and delivery of this information should be tested through further research and evaluation, so as to ensure that the information is clear and acceptable for a psychotic population.

Recommendation 2 **– National guidance should be developed concerning thresholds for providing crisis care for people with psychosis –** There are conflicting views amongst CRT staff around the suitability of treatment of acute psychosis in the community, which leads to an inconsistent experience for those using the service. National guidance would set expectations for both service users and CRT staff.

Recommendation 3 – **Whenever possible the CRT should remain transparent and open with service users with psychosis, around the likelihood of inpatient admission, assessment of symptoms and perceptions of risks**. This should be carefully delivered to aim to ensure that service users do not feel threatened, or coerced by such information and wherever possible in a manner that promotes control for service users.

Recommendation 4 **– CRT staff should carefully consider and limit the use of an authoritative role when working with service users with psychosis –** The adoption of an authoritative role was unanimously viewed negatively by service user participants, often seen as coercive or patronising. Guidance around thresholds for the use of such techniques should be developed, to support CRT staff on appropriate use, while facilitating control for service users wherever possible.

Recommendation 5 **– CRTs should provide information for service users at the point of crisis care –** this may contain:

1. Information about the condition and what is known about it
2. Information about treatment options
3. Ongoing information about the purpose and delivery of crisis care

Recommendation 6 **– CRTs should consider providing a timeline of events and an account of the period of crisis care for service users with psychosis, so as to support service users to understand their experience of crisis care** e.g. shared service user and CRT staff diaries, or routinely offered access to electronic medical records **–** This may help service users develop a greater understanding of their experience and increase control for the individual.

Recommendation 7 **– CRTs should provide formalised training for CRT staff of all professions, concerning the delivery of psycho-educational interventions for service users with psychosis.** Staff should be supported to feel confident in the treatment of people with psychosis and to deliver psychosis specific psycho-educational interventions to service users.

Recommendation 8 **– CRT staff should take care to ensure that a focus is placed upon understanding the impact of the symptoms for the service use and not just upon the symptoms themselves.** This may reduce experiences of depersonalised crisis care, for those with psychosis. The need for a biopsychosocial, person centred approach at the point of acute care was highlighted, due to a tendency to focus solely upon risks for those with psychosis.

Implications for future research

Confirming results in a broader population location & diversity

The evidence base would benefit from replication of the study, selecting participants from a broad variety of geographic locations. In particular, seeking views from participants in a mixture of urban, suburban and rural settings. This would allow a greater degree of

certainty in the generalisability of the findings and would demonstrate whether or not, the barriers and facilitators to the provision of successful crisis care for people with psychosis are the same regardless of the CRT used. Further research should target a greater diversity of participants, seeking to identify the barriers and facilitators to crisis care for people from a range of ethnicities, with immigrant status, no fixed abode and from other distinct cultural groups such as travelling communities, as these groups are likely to have unique needs that influence the provision of crisis care.

Due to limited resource, the views of carers, families and friends were not examined in this study. However, both service user and staff participants discussed these stakeholders during interviews. Future research should explore the role of carers, family and friends, in the delivery of crisis care for those with psychosis.

The findings from this study have been developed into a range of clinical recommendations for the provision of crisis care for people with psychosis. These recommendations could together form the basis for the development of a complex team level intervention. Using Delphi methods, a group of the major stakeholders might form a series of recommended changes to the provision of crisis care. This subsequent research should use the Medical Research Council's (MRC) guidance to developing and evaluating complex interventions (Craig et al., 2008) as steer for this work. The resulting complex intervention should be tested in a cluster randomised controlled trial.

Reflexions

This section outlines a reflexive enquiry, that acknowledges the integral role of the researcher in qualitative research. When adopting a semi-structured interview methodology, the researcher influences the questions asked of participants and in the analysis of interview data and the researcher makes decisions that concern the inclusion or exclusion of data. It is therefore impossible to claim there is complete objectivity, the role of the researcher must be acknowledged and transparent, with steps taken to help understand the conclusions of the study in this light (Patton, 2015). The researcher will have an impact upon the prevalence given to the different voices in the analysis, where dominant voices may be relayed, or a voice may be provided to those who are not as well heard (A. Coffey & Atkinson, 1996).

I undertook this research as I have a keen interest in the provision of mental health care. I originally worked for mental health charities, prior to working as a mental health researcher for the following eight years. In the latter position, I contributed to the development and delivery of two randomised controlled trials (RCT) examining CRTs. The first, an RCT examining the efficacy of peer support for people discharged from crisis care (S Johnson et al., 2018). The second, a cluster RCT examining the efficacy of a CRT service improvement programme. Both trials provided me with an in depth knowledge of CRTs and highlighted their crucial role in the broader mental health system. Further to this, I have delivered numerous other research studies focussed upon psychosis specifically and as such, hold a good degree of understanding around the impact of the disease. These experiences motivated me to conduct this research.

In the engagement work conducted by Bristol Health Partners (BHP) Psychosis Health Integration Team (HIT), service users with psychosis had highlighted the need to improve their experience of crisis care. As the need for the study came from service users and my previous research experience provided me with relevant expertise and understanding. I pursued the opportunity to develop and deliver the research.

I view my previous experience as largely beneficial to the delivery of the study. During the peer support RCT, I worked as part of the Bristol CRT for over a year and did so with some of the staff that took part in the interviews for this study. For the service improvement cluster RCT, I conducted semi-structured group interviews with CRT staff throughout the country.

My prior relationship with CRT staff was beneficial in terms of enabling the conduct and delivery of the study. However, the impact of this relationship the must also be considered in relation to the findings of the research. My existing relationship with staff, unavoidably influenced the research interviews and the analysis and interpretation of data. In particular, the existing relationship with some interview participants, led to a degree of informality in some interviews and a level of presumed knowledge around the delivery of crisis care and mental health services. As such, my questioning may have not delved as deeply with some topics, where other researchers potentially would. This issue was identified in the conduct of early interviews with a selection of transcripts reviewed by my supervisory team. Early identification, ensured that I was aware of this potential pitfall in future interviews and limit the impact of this dynamic upon the research findings.

When comparing the interviews that I conducted for this study with interviews with CRT staff for other studies, I view that the interviews from this study were perceived as more informal by CRT staff participants and led to a greater degree of candour around topics that were in some way controversial, or difficult to discuss. My pre-existing relationship with the staff meant that I was trusted. Overall I view this to have resulted in less formulaic discussion based upon CRTs operating policies and more around the human perspectives of CRT staff as individuals. Overall, I feel this benefited the purposes of this research highlighting a number of tensions between service user and staff perspectives.

My experience working within a CRT, provided me an in depth understanding of the challenges that CRT staff face in the provision of crisis care. This understanding may have impacted upon the strength of voice provided to service users or staff in the analysis of the data, where I may unintentionally provide support for the views of one stakeholder over another. Supervision was used to ameliorate the impact of this upon the objectivity of the research and the findings, where supervisors provided feedback upon interpretation of results. The study also used a conversational approach to reporting that attempted to give an account of the views of both service users and staff, providing as balanced a view as possible.

My previous research experience provided understanding of the difficulty that CRTs hold in maintaining service user satisfaction with its service. I view this as largely due to the acute nature of the work and the role of the CRT as inpatient gatekeepers. I did not expect the degree of impact that this is likely to have for those with psychosis in particular. Further to

this, I did not expect variation in CRT staff perspectives around the suitability of community treatment for those with acute psychosis.

Conclusion

Crisis Resolution Teams are well established throughout England, with evidence suggesting that they provide a viable and acceptable way of treating people with severe mental illness (Murphy et al., 2015). Despite NICE clinical guidelines for Psychosis (National Institute for Health and Care Excellence, 2014) recommending the provision of crisis care for those experiencing the acute phase of psychosis, they do not offer clear specifications around the optimal delivery of CRT intervention for this population. Through the examination of the barriers and facilitators to the provision of crisis care for people with psychosis, this study provides a valuable series of recommendations that enable a more highly specified, diagnosis specific delivery of crisis care, of interest nationally and internationally.

This study highlights the vital importance of control for those experiencing acute psychosis and the need for consideration around how service users can be supported to regain control through relationships with CRT staff and communications with the CRT. I make specific, implementable recommendations around the delivery of written and verbal information and consideration of control in clinical interactions, that will enable CRTs to support this need.

Analysis highlighted a heightened need for a biopsychosocial, person centred approach, for a population where an emphasis tends to be placed upon the management of the risks to self and others. I make recommendations to implement these considerations in clinical interactions, so as to improve the experience of crisis care for people with psychosis.

I make important recommendation for the development of national guidance concerning the thresholds for providing crisis care for people with psychosis. Interviews uncovered contrasting opinions, notably between different staff participants. This study highlights an urgent need to address a lack of clarity, that can result in the variable delivery of care.

Future research and evaluation should be conducted around the implementation of these recommendations.

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ANNEXES

ANNEX 1 – Literature Search Strategy

Medline

1. Medline exp PSYCHOTIC DISORDERS/ (45,174)
2. Medline exp SCHIZOPHRENIA/ (91,653)
3. Medline (psycho* OR schizo*).ti,ab (138,154)
4. Medline exp CRISIS INTERVENTION/ (5,318)
5. Medline exp COMMUNITY MENTAL HEALTH SERVICES/ (17,164)
6. Medline exp EMERGENCY SERVICES, PSYCHIATRIC/ (2,217)
7. Medline (crisis OR crises).ti,ab (45,968)
8. Medline (1 OR 2 OR 3) (232,947)
9. Medline (4 OR 5 OR 6 OR 7) (67,666)
10. Medline QUALITATIVE RESEARCH/ (30,809)
11. Medline "INTERVIEWS AS TOPIC"/ (49,367)
12. Medline *"INTERVIEWS AS TOPIC"/ (3,823)
13. Medline (theme* OR thematic).ti,ab (68,819)
14. Medline (qualitative).af (175,673)
15. Medline (questionnaire*).ti,ab (386,725)
16. Medline (ethnological ADJ2 research).ti,ab (8)
17. Medline (ethnograph*).ti,ab (7,844)
18. Medline (grounded ADJ (theor* OR study OR studies OR research OR analys?s)).ti,ab (8,599)
19. Medline ((purpos* ADJ4 sampl*) OR (focus ADJ group*)).ti,ab (40,456)
20. Medline (account OR accounts OR unstructured OR open- ended OR open ended OR text* OR narrative*).ti,ab (493,787)
21. Medline (content ADJ1 analysis).ti,ab (18,881)
22. Medline ((discourse* OR discurs*) ADJ3 analys?s).ti,ab (1,740)
23. Medline (narrative ADJ2 analys?s).ti,ab (1,368)
24. Medline (10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23) (1,100,474)
25. Medline (8 AND 9 AND 25) (463)

EMBASE

1. EMBASE exp PSYCHOTIC DISORDERS/ (258,027)
2. EMBASE exp SCHIZOPHRENIA/ (170,528)
3. EMBASE (psycho* OR schizo*).ti,ab (801,411)
4. EMBASE exp CRISIS INTERVENTION/ (6,209)
5. EMBASE exp COMMUNITY MENTAL HEALTH/ (4,152)
6. EMBASE exp SOCIAL PSYCHIATRY/ (3,428)
7. EMBASE (crisis OR crises).ti,ab (58,466)
8. EMBASE "QUALITATIVE RESEARCH"/ (51,303)
9. EMBASE INTERVIEW/ OR "DATA COLLECTION METHOD"/ (212,586)
10. EMBASE (theme* OR thematic).ti,ab (84,811)
11. EMBASE (qualitative).ti,ab (195,217)
12. EMBASE (questionnaire*).ti,ab (550,195)
13. EMBASE (ethnological ADJ2 research).ti,ab (10)
14. EMBASE (narrative ADJ2 analys?s).ti,ab (1,246)
15. EMBASE (ethnograph*).ti,ab (8,474)
16. EMBASE (grounded ADJ (theor* OR study OR studies OR research OR analys?s)).ti,ab (9,996)
17. EMBASE ((purpos* ADJ4 sampl*) OR (focus ADJ group*)).ti,ab (48,409)
18. EMBASE (account OR accounts OR unstructured OR open-ended OR open ended OR text* OR narrative*).ti,ab (580,406)
19. EMBASE (content ADJ1 analysis).ti,ab (19,323)
20. EMBASE ((discourse* OR discurs*) ADJ3 analys?s).ti,ab (1,803)
21. EMBASE (8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20) (1,482,957)

22. EMBASE (1 OR 2 OR 3) (889,717)
23. EMBASE (4 OR 5 OR 6 OR 7) (69,503)
24. EMBASE (31 AND 32 AND 33) (1,934)

PsycINFO

1. PsycINFO exp SCHIZOPHRENIA/ (80,680)
2. PsycINFO (psycho* OR schizo*).ti,ab (298,788)
3. PsycINFO exp PSYCHOSIS/ (102,927)
4. PsycINFO exp CRISIS INTERVENTION/ (7,058)
5. PsycINFO EMERGENCY SERVICES, PSYCHIATRIC/ (1,121)
6. PsycINFO (crisis OR crises).ti,ab (31,399)
7. PsycINFO "COMMUNITY MENTAL HEALTH"/ OR "COMMUNITY MENTAL HEALTH SERVICES"/ OR "COMMUNITY PSYCHIATRY"/ (16,379)
8. PsycINFO (1 OR 2 OR 3) (365,585)
9. PsycINFO (4 OR 5 OR 6 OR 7) (52,364)
10. PsycINFO "QUALITATIVE RESEARCH"/ OR "GROUNDED THEORY"/ OR INTERVIEWS/ OR "OBSERVATION METHODS"/ OR "EXPERIMENTAL DESIGN"/ OR EXPERIMENTATION/ (99,537)
11. PsycINFO (theme* OR thematic).ti,ab (100,406)
12. PsycINFO (qualitative).ti,ab (121,004)
13. PsycINFO (questionnaire*).ti,ab (230,270)
14. PsycINFO (ethnological ADJ2 research).ti,ab (19)
15. PsycINFO (narrative ADJ2 analys?s).ti,ab (2,792)
16. PsycINFO (ethnograph*).ti,ab (22,115)
17. PsycINFO (grounded ADJ (theor* OR study OR studies OR research OR analys?s)).ti,ab (12,942)
18. PsycINFO ((purpos* ADJ4 sampl*) OR (focus ADJ group*)).ti,ab (32,549)
19. PsycINFO (account OR accounts OR unstructured OR open-ended OR open ended OR text* OR narrative*).ti,ab (291,974)
20. PsycINFO (content ADJ1 analysis).ti,ab (18,445)
21. PsycINFO ((discourse* OR discurs*) ADJ3 analys?s).ti,ab (6,826)
22. PsycINFO (10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21) (765,128)
23. PsycINFO (8 AND 9 AND 22) (1,100)

ANNEX 2 – Staff Participant Information Sheet

Crisis Response for Psychosis
Study Information Sheet for Staff

We would like to invite you to take part in our study and the following information tells you what is involved. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
This study is investigating the views of people who are involved in providing crisis care for people with psychosis.

Why have I been asked to take part?
You have been invited to take part because you work in the Bristol Crisis Services. Your opinions about the barriers and facilitators in providing care to this client group, will help us understand how to make the health care we provide better. In subsequent work, we will aim to make changes to services based upon what we find.

Do I have to take part?
No, it is up to you. If you decide not to take part, you do not need to give a reason and it will not affect your role.

What will happen to me if I take part?
You will be invited to take part in an interview either in person with a researcher, or as a telephone interview. With your permission the researcher will audio-record the interview. This interview will involve answering some questions set by the interviewer, but also telling us what you think. The interview will probably take about 1 hour to complete.

What are the possible benefits of taking part?
You will help us understand how to improve Crisis Resolution Teams.

What are the possible disadvantages of taking part?
The only disadvantage is the time taken to talk to the researcher. Some people may find it distressing to discuss their experiences. If you do find that you are experiencing distress during the interview, the researcher will offer time for you to pause or stop the interview completely. The researcher will be experienced in working in this way and will support you if possible. If you are still distressed, the researcher will speak to you about people who can support you at that time.

Is the study confidential? Yes, all information you give us will be kept strictly confidential. In the unlikely event of poor practice being uncovered during the research, the researcher would have a duty of care to discuss this with their supervisors and confidentiality will be

broken in line with the NHS Code of Conduct. Examples of this may be clinical malpractice, bullying or Fraud.

Data will be stored on password protected computers for 3 years in a way which makes it impossible for it to be linked to you, except by a few members of the research team. Anonymous quotes may be published, but no names or identifying details will be reported so it will not be possible to trace who said them. Other Staff at the Crisis Resolution Team will not be told that you have participated in the study or anything about your responses to any of the questions. People who use services will not be told who has taken part.

Who is carrying out the research?
The Crisis Response for Psychosis Study is managed by the Avon and Wiltshire Mental Health Partnership NHS Trust and the University of Bristol. The team is led by Dr Sarah Sullivan from the University of Bristol.

What happens to the results of the research study?
The results of this study will be shared by reports in medical and health journals, newsletters and at conferences so other people can learn from your experience. Anonymous quotes may be published, but no names or identifying details will be reported so it will not be possible to trace who said them.

What if I change my mind?
Taking part is voluntary and you are free to leave the study at any time, without giving a reason, and without your legal rights being affected.

Where can I get further information?
If there is anything you do not understand or if you would like more information, please do not hesitate to contact a member of the research team.

Research Associate
Research and Development, Avon and Wiltshire Mental Health Partnership NHS Trust
Jonathan.piotrowski@nhs.net
0117 378 4266
Study Chief Investigator: Dr Sarah Sullivan
Sarah.Sullivan@bristol.ac.uk
0117 331 3322

What if I am unhappy with the research?
If you have any concerns about the way you have been treated during the course of the research, the researcher will be very happy to discuss this with you. You could also contact the Study Lead or the Study researcher, whose contact details are above. If you wish to complain formally you can contact the study sponsor

Avon and Wiltshire Mental Health Partnership NHS Trust
Hannah Antoniades
Associate Director of Research and Development
Hannah.antoniades@nhs.net

0117 378 4267

Who has reviewed the study?
The study has been reviewed favourably by researchers in the UK with considerable research experience and the Frenchay South West Research Ethics Committee [IRAS ID 206786].

Thank you for reading this information sheet

ANNEX 3 – Service User Participant Information Sheet

Crisis Response Study
Study Information Sheet for Service Users

We would like to invite you to take part in our study and the following information tells you what is involved. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
This study is investigating the views of people who have used NHS Crisis Resolution Teams. You may also know the team as the Bristol Intensive Team.

Why have I been asked to take part?
You have been invited to take part because you are using or have recently used the Bristol Crisis Services. Your opinions about what worked well and what could be improved with the service, will help us understand how to make the healthcare we provide better.

Do I have to take part?
No, it is up to you. If you decide not to take part, you do not need to give a reason and it will not impact your care in any way.

What will happen to me if I take part?
You will be invited to take part in an interview either in person with a researcher, or as a telephone interview. With your permission the researcher will audio-record the interview. This interview will involve answering some questions set by the interviewer, but also telling us what you think. The interview will probably take about 1 hour to complete. **You will receive a £10 gift voucher to say thank you for your help with this work.**

What are the possible benefits of taking part?
You will help us understand how to improve Crisis Resolution Teams.

What are the possible disadvantages of taking part?
The only disadvantage is the time taken to talk to the researcher, this will be around 1 hour. The interview will discuss your experiences when you were using a mental health crisis team. Some people may find it distressing to discuss this experience. If you do find that you are experiencing distress during the interview, the researcher will offer time for you to pause or stop the interview completely. The researcher will be experienced in working in this way and will support you if possible. If you are still distressed, the researcher will speak to you about people who can support you at that time and discuss the option of speaking to your care team.

Is the study confidential? Yes, all information you give us will be kept strictly confidential. Data will be stored on password-protected computers for 3 years in a way which makes it

impossible for it to be linked to you by anyone outside the research team. Anonymous quotes may be published, but no names or identifying details will be reported so it will not be possible to trace who said them.

Staff at the Crisis Resolution Team or other health service staff responsible for your care will not be told that you have participated in the study or anything about your responses to any of the questions. The only exception to this is if the researcher interviewing you has reasons to be concerned about your or someone else's immediate safety following the interview. In this situation, the researcher would contact mental health NHS staff that know you to pass on these concerns.

Who is carrying out the research?
The Crisis response study is managed by the Avon and Wiltshire Mental Health Partnership NHS Trust and the University of Bristol. The team is led by Dr Sarah Sullivan from the University of Bristol.

What happens to the results of the research study?
The results of this study will be shared by reports in medical and health journals, newsletters, and conferences so that other people can learn from your experience. Anonymous quotes may be published, but no names or identifying details will be reported so it will not be possible to trace who said them.

What if I change my mind?
Taking part is voluntary and you are free to leave the study at any time, without giving a reason, and without your health care or your legal rights being affected.

Where can I get further information?
If there is anything you do not understand or if you would like more information, please do not hesitate to contact a member of the research team.

Research Assistant
Research and Development, Avon and Wiltshire Mental Health Partnership NHS Trust
Jonathan.piotrowski@nhs.net
0117 378 4266

Study Chief Investigator: Dr Sarah Sullivan
University of Bristol
Sarah.Sullivan@bristol.ac.uk
0117 331 3322

What if I am unhappy with the research?
If you have any concerns about the way you have been treated during the course of the research, the researcher will be very happy to discuss this with you. You could also contact the Study Lead, whose contact details are above. If you wish to complain formally, or have any unresolved concerns about any aspect of the way you have been approached or treated during the course of this study, you can contact your local NHS Advice and Complaints Service:

PALS Office
Avon and Wiltshire Mental Health Partnership NHS Trust
Jenner House
Langley Park Industrial Estate
Chippenham
Wiltshire
SN15 1GG

Telephone: 01249 468261
Freephone: 0800 073 1778
Fax: 01249 468266
Email: awp.pals@nhs.net

Who has reviewed the study?
The study has been reviewed favourably by researchers in the UK with considerable research experience and the Frenchay South West Research Ethics Committee [IRAS ID 206786].

Thank you for reading this information sheet

ANNEX 4 – CRT Staff Interview Topic Guide

1. Background

- Background information on participant (e.g. age, ethnicity, location, LOS)
- How long have you worked in crisis services?
- Have you worked in any other teams
    a. Are there any differences?

2. Defining crisis

- What is a mental health crisis to you?
- How do you know whether someone is in a crisis?
- What is a crisis for someone experiencing psychosis
    - What differences are there for this population?
    - Capacity / MHA assessment, Medication, Risks
    - Does that make a difference to providing care?
    - What is your role as a crisis worker?

3. Team access & usage

- Are there any barriers that people with psychosis can face in accessing the team?
    - Communication, hospitalisation, service use HX.
    - How do you manage these barriers?
- Do you find that people are receptive to crisis team input?
    - What tends to happen in these circumstances?
    - Who is / isn't? – Why?
    - How do you manage this?
- Engagement
    - Do you have any techniques that you use to engage with people with psychosis.
    -

4. Visits

- What tends to be the purpose of home visits?
    - Do you always feel as though there is a purpose?
- How do you feel about the format of visits?
    - JV (differences), length of visit?, arranging/changing times.
- What can you provide for people experiencing psychosis?
    - Interventions?
    - Information – CRT purpose, what can be achieved, directory, staff?
    - Is there anything that would like to provide that you don't?
- Environment

4. Clinical Approaches / interactions

- How do you find working with people with psychotic symptoms?
    - Do you feel as though the crisis team works well with this population?
    - Are there other populations which are more difficult?
- How do psychotic symptoms impact on providing care?
    - How do you manage psychotic symptoms?
    - Do you use any specific techniques?
    - Do you engage with delusions? How do you decide whether to or not?
- What are there barriers to communicating with people experiencing psychotic symptoms?
    - How do you manage this?
    - Are there any methods you use to overcome these barriers?
- How do you manage situations where you are unsure whether you have the whole picture?
    - Do you find that people often withhold information? Why?
    - What is the impact of this?
    - How do you try and overcome this?
- What makes a crisis worker effective? Personality types, Training, Experience
    - What is the most important attribute a crisis worker can have?
- Do you get the sense that Service users do not feel as though you're on their side?
    - How do you manage this?
- What do you do to try and do make people feel better?

6. Service Improvements / close.

- Would you make any changes to the care you provide to this population?
    - Why?
    - Are there any other changes that you would make?
        - Continuity of care, visits, therapies, resources, information
    - Is there anything additional that crisis teams could do for people with psychosis?
- If you could tell people with psychosis one thing about providing crisis care, what would it be?
    - Are there differences around what you can provide and what people expect?
- Is there anything else you would like to say that we have not spoken about?

ANNEX 5 – Service user Interview Guide

1. Background

- Background information on participant (e.g. age, ethnicity, location)
- Can you start off by telling me how your health is in general?
- When was your first contact with mental health services
- When have you used the crisis team in the past?

2. Team usage and access

- What happened? How di d you end up using the team?
- Did you understand what the team was for at the time?
- Was it easy for you to get help?
- Did you find anything difficult about the getting help? Was there any thing good?
- Was it something that you wanted to do?
- Were family carers involved? What role did they have? Were they supported?

3. Experience

- What is a mental health crisis to you?
- What was the most difficult thing about your experience?
    - Did the crisis team help with this? How?
    - Could they have done anything differently? More?
- Where you able to discuss what you were experiencing with the team?
    - Did they acknowledge your experiences
        - Was this helpful? Why?
- What did the team do well? What could they have done differently?
- What did the team ask you to do? Was it helpful? Did you want to?
- How did you find the visits? Why?
- How did you find the staff? Why?

4. Do you view the crisis team negatively or positively?

- What was it that made you feel this? How did you feel you were treated by the team?
- Do you feel as though you were involved in decisions made about you?
- Do you feel as though that the decisions made were in your best interest?

If negatively, why? What happened to give you that view? How did the experience make you feel?
If positively why? How did the experience make you feel? What happened to give you that view?

- When you think about it now, what do you remember about the team?
- Was there any one person that sticks out in your mind?
    - What is it about that person?
    - What did/nt they do?

5. Improvements to the Team

- Where could there be improvements?
    - Visits? Why?
        - Arranging, Timeliness, Length of visit, Regularity, Purpose, overwhelming?
    - Staff? Why?
        - Identify, Attitudes, Behaviours, Understanding, Caring, Sensitive Individualised, rapport, informed?
    - Information? Why?
        - Around services, who to contact, available resources?
    - Continuity of care? Why?
        - Did you use any other services either before or after the Crisis Team?
        - Did you feel properly informed about what was happening?

- If you could change one thing, what would that be?
- Can you think of anything that, in an ideal world, would have been provided?

Notes

6. What is a crisis to you?

- What do you need in those circumstances / when you feel like that?

ANNEX 6 – Distress Protocol

Crisis Response for Psychosis Distress Protocol

Pre Interview – Make sure that the participant is fully informed before you even meet

1. Provide information about the purpose of the study and the likely contents of the interview at least 24 hours prior to consent
2. Ensure the participant knows that participation is voluntary and they are free to withdraw at any time

Initial Distress - If the participant says that they are experiencing distress or it is visible that the participant is experiencing discomfort or distress

3. Offer the participant the opportunity to pause
4. If necessary, terminate interview and stop recording equipment
5. Listen to interviewee and offer support in situ
6. Be aware of boundaries and responsibilities. avoid teaching, preaching or counseling

Review – If the participant feels able to continue, then carry on. If distress continues or worsens

7. Stop the interview
8. Ask participant if there is anyone they can contact
9. Discuss the possibility of making contact with the participant's current care team.
10. Where risk is perceived contact current Care Coordinator, or the crisis service under which the service user was recently treated.

Follow up – Attend Supervision with CI as soon as possible and discuss the incident